Evidence-Based Series #17-1 Version 2

A Quality Initiative of the
Program in Evidence-Based Care (PEBC), Cancer Care Ontario (CCO)

Thoracic Surgical Oncology Standards

The Expert Panel on Thoracic Surgical Oncology

A Special Project of the Surgical Oncology Program, Cancer Care Ontario and
The Program in Evidence-Based Care, Cancer Care Ontario
Developed by the Expert Panel on Thoracic Surgical Oncology

An assessment conducted in December 2016 deferred the review of Evidence-based Series (EBS) 17-1 Version 2. This means that the document remains current until it is assessed again next year. The PEBC has a formal and standardized process to ensure the currency of each document (PEBC Assessment & Review Protocol)

The reviewed EBS report, which is available on the CCO website, consists of the following four sections:

Section 1: Standards (ENDORSED)
Section 2: Systematic Review (available from ccopgi@mcmaster.ca).
Section 3: Guideline Development and External Review - Methods and Results
Section 4: Document Review Summary and Tool

Release Date: March 4, 2015

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Guideline Report History

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Thoracic Surgical Oncology Standards

S. Sundaresan, B. Langer, T. Oliver, F. Schwartz, M. Brouwers, H. Stern, and the Expert Panel on Thoracic Surgical Oncology

A Special Project of the Surgical Oncology Program, Cancer Care Ontario and The Program in Evidence-Based Care, Cancer Care Ontario. Developed by the Expert Panel on Thoracic Surgical Oncology.

Report Date: September 9, 2005

These guideline recommendations have been ENDORSED, which means that the recommendations are still current and relevant for decision making. Please see Section 4: Document Review Summary and Tool for a summary of updated evidence published between 2005 and 2013, and for details on how this Clinical Practice Guideline was ENDORSED.

Question
What is the optimum organization for the delivery of cancer-related thoracic surgery in Ontario?

Scope of Standards
The following standards, developed by the Expert Panel on Thoracic Surgical Oncology, apply to thoracic surgical oncology and include the full spectrum of multi-disciplinary assessment and treatment.

Surgeon Criteria
General characteristics for surgeons undertaking the management of patients with thoracic cancer are as follows:
- Knowledgeable about thoracic cancer biology, behaviour, and natural history.
- Well informed of appropriate investigation techniques, multidisciplinary treatment options as well as postoperative management and the continuum of care.
- Skilled in modern techniques of surgery of the thoracic region.
- Experienced in the management of patients with thoracic diseases, specifically, the management of their complications, early and late.
- Committed to providing excellence in care to patients with thoracic diseases, specifically cancer patients, and to advancing knowledge in the field to improve patient outcomes.
• Committed to participating as a member of a multidisciplinary oncology team or to consulting with such teams.
• Committed to participating in Cancer Care Ontario initiatives, particularly those of the Surgical Oncology Program, and/or in the Program in Evidence-Based Care through membership in working groups, standing groups, or as active participants in external review and consultation processes.

Training
• Surgeons should have completed formal training in programs such as the Royal College of Physicians and Surgeons of Canada (RCPSC) programs in thoracic surgery, cardiothoracic surgery or cardiovascular and thoracic surgery, or the American Board of Thoracic Surgery or other equivalent training recognized in Canada, and be certified and licensed to practice thoracic surgery in Canada.
• Surgeons should maintain expertise and competence through ongoing education in available Continuing Professional Development (CPD) programs, such as the Maintenance of Certification (MOC) program of the RCPSC or others.

Practice Setting
• Level 1 Tertiary care regional thoracic centres should be equipped to manage the full range of thoracic surgical care, as well as acting as the primary source to manage the most complex cases. To facilitate this goal, there should ideally be at least three thoracic surgeons on staff to provide intraoperative assistance and postoperative care, and weekend, holiday and emergency coverage.
• This number of surgeons is needed to provide the capacity for tertiary clinical care in addition to the other requirements and responsibilities of a multidisciplinary cancer care facility, including teaching, research, quality improvement, and program advancement.
• A team approach is understood to improve the quality of surgery in complex cases and the judgment required to manage complications.

• In some regions of the province, the population may not support a Level 1 thoracic centre. In these regions, a Level 2, or secondary care unit, may be established to serve the basic thoracic surgery needs of the population.
• Level 2 centres should have:
  o A minimum of one thoracic surgeon who performs routine thoracic procedures.
  o A formalized relationship with a Level 1 tertiary centre to which the thoracic surgeon may refer complex thoracic cases (e.g., tracheal resections, major chest wall resections, etc.).
  o Arrangements with surgical colleagues in those centres to provide support in the event of the thoracic surgeon’s absence.
• Hospitals not meeting Level 1 or 2 thoracic surgery criteria should establish formal relationships with a Level 1 or Level 2 centre to facilitate consultation, appropriate management and referral of patients with thoracic malignancies. For those hospitals where the geographic location, patient volume or population catchments do not support Level 1 or 2 status, the basic thoracic service needs may still be provided in that area through formal relationships with Level 1 and 2 centres. Guided by the expertise of these centres, much of the initial/pre-operative evaluation can be conducted at that hospital itself. The surgical care would require transferring the patient to the Level 1 or 2 Thoracic surgery unit. However, upon completion of the surgery, the patients can return to the
originating centre for ongoing care and follow-up as deemed appropriate and necessary by the multidisciplinary group at the Level 1 or 2 centre.

Volume of Thoracic Surgery

- The practice setting should have a sufficient volume of thoracic surgery to maintain the skills of surgeons in both complex cancer surgery and thoracic surgery.
- Surgical volumes of a minimum of 20 esophagectomy cases per unit per year and 150 pulmonary resections per unit per year should be considered targets for Level 1 centres.
- Surgical volumes of a minimum of 7 esophagectomy cases per unit per year and 50 pulmonary resections per unit per year should be considered targets for Level 2 centres.
- These volumes were considered reasonable by the expert panel in light of the current distribution of thoracic surgery in the province, but it is recommended that these numbers be revisited as more data becomes available.
- The panel recognized that some regions may not have the population and cases to support the recommended target volumes, but could meet them as the predicted increase in cancer cases occurs.

Qualifying Statements - Added in the Update and Endorsement in March, 2015

The original 2005 recommendations on surgical volumes were modified in 2015 by the Expert Panel. The words ‘in the range’ and ‘anatomic’ were deleted. See Section 4, page 16 for additional information.

The original and the revisions to the surgical volume target recommendations are based on the expert opinion of the guideline panels. In the updated literature review (to December 2013) no new data were identified to inform the volume target recommendations.

Hospital Criteria

Important characteristics of the institution in which major thoracic cancer surgery would take place are:

- Commitment to high-quality multidisciplinary thoracic cancer care.
- Commitment to providing or participating in an organizational structure to manage patients with these cancers through all phases of their care.
- Commitment to participate in activities that advance CCO’s Provincial Cancer Plan (2004).
- Formal working relationship or association with a regional cancer centre, if a thoracic surgery unit is not located at the cancer centre.

Physical Resources and Collaborating Services

The following physical resources and collaborating services are considered to be reasonable criteria which Level 1 and 2 hospitals providing thoracic cancer surgery should be expected to meet in providing comprehensive acute care:

- Operating Room that is available 24 hours per day, 7 days per week (24/7), with video capacity for bronchial and esophageal scopes, Video Assisted Thoracic Surgery (VATS) and laparoscopy, intra-operative fluoroscopy capacity, and frozen section available 24/7 for emergencies.
- An interventional radiology suite that has the capacity for needle biopsy of lung and chest masses and drainage of loculated pleural collections and that is available 24/7 for emergencies, either onsite or at an on-call hospital. The capacity for embolization
therapy for massive hemoptysis or prior to massive chest wall resections is essential for Level 1 centres.

- Full spectrum of radiological imaging, including X-ray and immediate portable X-ray access 24/7 for emergencies, esophageal contrast studies, CT, MRI, ultrasound, nuclear medicine and vascular imaging.
- For Level 1 units - a dedicated thoracic surgical service with consolidated beds to ensure an appropriate level of nursing, physiotherapy and respiratory therapy expertise.
- Specialized nursing care, including mechanical ventilation and invasive monitoring in a combination of ICU and step-down beds sufficient to support the volume of patients treated.
- Affiliation with a regional cancer centre, with access to radiation therapy equipment and consultation from medical and radiation oncologists.
- Ambulatory endoscopy facility with access to surgeons, pulmonologists and gastroenterologists.
- On-site lab for pulmonary function tests (PFT), cardiac diagnostic assessment services, including echocardiography and nuclear imaging.
- On-site rapid response laboratory (i.e., biochemistry, hematology, transfusion and microbiology) services sufficient to support operating room, ICU, step-down and ward requirements 24/7.
- On-site or rapid access pathology and cytology services sufficient to support operating room, endoscopy and ambulatory services.

**Human Resources**

**Human Resources should include:**

- Thoracic surgeons.
- Anesthesiologists skilled in thoracic anesthesia techniques.
- Other medical specialists including gastroenterologists, pulmonary medicine specialists, intensivists, a thoracic pathologist and a radiologist with a subspecialty interest in diagnostic and interventional procedures in the chest.
- Allied professionals, including dedicated nurses; chest physiotherapists accessible 7 days a week; respiratory therapists available 24/7; dietary/nutritional, home care, social work, and pharmacy support; and access to a palliative care team.
- Formalized partnerships and access to oncology specialists including medical oncologists and radiation oncologists.
  - Access to other consulting specialties as needed, such as infectious disease, cardiology and neurology specialists.

**Organizational Criteria**

- The successful management of patients with thoracic problems, particularly those with thoracic malignancies, by involving a multidisciplinary team approach with the use of standard diagnostic and treatment protocols and the involvement of a variety of surgical and non-surgical specialists.
- For Level 1 units - a designated thoracic unit with identified leadership and accountability.
- A system of regular review of multidisciplinary patient management (e.g. multidisciplinary clinics, clinical rounds, educational rounds, morbidity and mortality review, and formal ongoing outcome measurements and quality assurance) is essential for the achievement of optimal patient outcomes.
• Participation in regional and provincial integrated networks of care as outlined in the CCO Provincial Cancer Plan (2004) to facilitate patient access, consultation, referral, quality improvement and continuing professional development.
• Infrastructure support for participation, and the participation, of patients in clinical research in thoracic care, both in local and national studies.

Development of the Standards Document
Evidence on thoracic cancer surgery was gathered through a systematic search of the literature and a scan of documents from organizations concerned with thoracic surgery quality practice. Evidence was reviewed by members of the Expert Panel on Thoracic Cancer Surgical Oncology (see Appendix 1, Section 3) investigating the delivery of cancer-related thoracic surgery in Ontario.

The panel included thoracic surgeons, general surgeons, a medical oncologist, a radiation oncologist, social and behavioural scientists, a hospital Chief Executive Officer, a Cancer Care Ontario Regional Vice President, pathologists, radiologists and methodologists, and representatives from the Canadian Association of Thoracic Surgeons and the Ontario Association of General Surgeons, with representation from across the province.

The standards were developed using a combination of evidence-based analysis, existing recommendations from other jurisdictions, and incorporated expert opinion based on experience and consensus. The panel analyzed data on the current distribution of thoracic cancer surgery across Ontario to inform the process of developing volume standards for Ontario. The standards were developed to accommodate long-range needs and take into account the projected increase in thoracic cancer surgery needs over the next decade due to a growing and aging population.

Related Guidance Documents
This inventory of related guidance has been updated to include documents published up to March 2015. These complementary guidance resources provide additional recommendations for the care of patients with lung cancer.

• Guidelines for the care of lung cancer patients have been developed by the Lung Cancer Disease Site Group (DSG) and can be accessed at this webpage: https://www.cancercare.on.ca/cms/One.aspx?portalId=1377&pageId=10286

• PEBC EBS#7-20 Version 2: 18-Fluorodeoxyglucose Positron Emission Tomography in the Diagnosis and Staging of Lung Cancer (available at: https://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=34341)

• PEBC EBS#7-18: Positron Emission Tomography in Radiation Treatment Planning for Lung Cancer (available at: https://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=86361)

• PEBC EBS#7-14 Version 2: Surgical Management of Malignant Pleural Mesothelioma (available at: https://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=34334)


• PEBC EBS # 15-10: Screening high risk populations for lung cancer (available at: https://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=287881)


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Section 1: Standards
Evidence-Based Series #17-1 Version 2: Section 2

Thoracic Surgical Oncology Standards: A Systematic Review

S. Sundaresan, B. Langer, T. Oliver, F. Schwartz, M. Brouwers, H. Stern, and the Expert Panel on Thoracic Surgical Oncology

A Special Project of the Surgical Oncology Program, Cancer Care Ontario and The Program in Evidence-Based Care, Cancer Care Ontario. Developed by the Expert Panel on Thoracic Surgical Oncology.

Report Date: September 9, 2005


A pdf version of The Annals of Thoracic Surgery publication is available separately on the CCO Web site at [Thoracic Standards Systematic Review](http://ccopgi@mcmaster.ca), with the understanding that the pdf version has been:


Section 2: A Systematic Review can be obtained by contacting the PEBC office at [ccopgi@mcmaster.ca](mailto:ccopgi@mcmaster.ca).
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Evidence-Based Series #17-1 Version 2: Section 3

Thoracic Surgical Oncology Standards:
Guideline Development and External Review - Methods and Results

S. Sundaresan, B Langer, T Oliver, F Schwartz, M Brouwers, H Stern
and the Expert Panel on Thoracic Surgical Oncology

A Special Project of the
Surgical Oncology Program, Cancer Care Ontario and
The Program in Evidence-Based Care, Cancer Care Ontario.
Developed by the Expert Panel on Thoracic Surgical Oncology.

Report Date: September 9, 2005

THE SURGICAL ONCOLOGY PROGRAM AND THE PROGRAM IN EVIDENCE-BASED CARE COLLABORATION
The Surgical Oncology Program (SOP) and the Program in Evidence-based Care (PEBC) are initiatives of Cancer Care Ontario (CCO). The mandate of the SOP is to improve the delivery of cancer surgery in Ontario through initiatives designed to increase access to care, improve the quality of care, support the recruitment and retention of cancer surgeons, support knowledge transfer and evidence-based practice and foster research and innovation. The mandate of the PEBC is to improve the lives of Ontarians affected by cancer, through the development, dissemination, implementation, and evaluation of evidence-based products designed to facilitate clinical, planning, and policy decisions about cancer care.

The PEBC is best known for producing high-quality evidence-based practice guideline reports, using the methods of the Practice Guidelines Development Cycle (1,2). A typical PEBC report consists of the comprehensive systematic review of the clinical evidence on a specific cancer-related topic, the interpretation of and consensus agreement on that evidence, the resulting clinical recommendations, and the results of an external review by Ontario clinicians for whom the topic is relevant. The PEBC has a formal standardized process to ensure the timeliness of each clinical practice guideline report, conducting routine periodic reviews and evaluations of the scientific literature and, where appropriate, integrating that literature with the original practice guideline report information.

The SOP and the PEBC have worked collaboratively on a number of occasions to develop evidence-based materials relevant to the surgical community in Ontario, which includes the creation of thoracic surgical oncology standards.

As part of its quality improvement mandate, the SOP convenes expert panels for the selection of quality indicators and the development of clinical guidelines and organizational standards. The panels are comprised of surgeons, other clinicians and methodologists and are
established on an as-needed basis for specific quality initiatives, such as the development of the thoracic surgical oncology standards.

In this instance, the SOP coordinated the development of the Expert Panel on Thoracic Surgical Oncology and the PEBC contributed methodological expertise. The PEBC process and report format has been adapted for the thoracic standards document.

The Evidence-Based Series
This Evidence-Based Series is comprised of the following three sections:

- **Section 1: Standards**
  This section contains the standards derived by the Expert Panel on Thoracic Surgical Oncology Standards through systematic review, an environmental scan, interpretation of the clinical and scientific literature and consensus process, as well as through a formalized external review by Ontario practitioners and administrators.

- **Section 2: Systematic Review**
  This section presents the comprehensive systematic review of the clinical and scientific research, the environmental scan and panel discussion on the topic and the conclusions drawn by the Expert Panel on Thoracic Surgical Oncology Standards.

- **Section 3: Methodology of the Guideline Development and External Review Process**
  This section summarizes the standards development process and the results of the formal external review by Ontario practitioners and administrators of the draft version of the thoracic surgical oncology standards and systematic review.

DEVELOPMENT OF THE EVIDENCED-BASED SERIES
Developing the Draft Systematic Review and Standards
This Evidence-Based Series was developed by the Expert Panel on Thoracic Surgical Oncology Standards. The series is a convenient and up-to-date source of the best available evidence developed through systematic review, evidence synthesis, and input from practitioners and administrators in Ontario. Section 2 contains the systematic review of the evidence on outcomes related to the optimum delivery of cancer-related thoracic surgery. The draft recommendations derived from the interpretation of that evidence by members of the expert panel are detailed in Section 1. Sections 1 and 2, along with Section 3, are circulated to Ontario practitioners and administrators for their feedback. Section 3 presents the feedback process results, any changes made to the draft document.

Practitioner Feedback
Practitioner and administrator feedback was obtained through a mailed survey of 132 practitioners and administrators in Ontario (primarily surgeons, thoracic surgeons, and hospital administration). The survey consisted of items evaluating the methods, results, and interpretive summary used to inform the draft standards and whether the draft standards should be approved as a provincial guidance document.

Sixty-three responses were received out of the 132 surveys sent (48% response rate). Of the 63 respondents, 56 completed the questionnaires and 42 provided written comments.

The items that 80% or more respondents agreed to were the rationale and need for thoracic surgery standards in Ontario, the methodology used, the interpretation of the data in the systematic review, the clarity of the standards report, and the perceived comfort level of patients and practitioners if the care outlined in the standards document were offered. Seventy 70% of the respondents agreed with the draft standards as stated, and 75% agreed that the draft standards would produce more benefits than harms.

Roughly half of the respondents agreed that the standards would be suitable and acceptable to the system, would not be too rigid or expensive to apply, but would also
require service re-organization and would be technically challenging. About half agreed that the standards would be supported by a majority of colleagues and that expected patient outcomes would be obvious. In a comparison of the proposed standards to current thoracic surgery practice, approximately 20% of respondents indicated that their centres were already practicing the type of care outlined in the standards document. Roughly half of respondents agreed that the standards would reflect a more effective approach for improving patient outcomes and, when applied, would reflect a more effective use of resources.

In terms of formal approval as a CCO standards document, 56% of respondents agreed that the document should be formally approved, 25% were unsure, and 19% disagreed with formal approval. Approximately half of respondents agreed with the statements that they (55%) or their centre (46%) would be likely to apply the standards if formally approved. The remaining respondents were either unsure, (26% and 15% respectively) or disagreed with the statements (28% and 28% respectively).

The respondents also provided written comments. The major themes emerging from the comments provided by the respondents included:

- support for the document or the process of standardization of thoracic oncology surgery (12 comments in total),
- comments regarding the volume of thoracic surgery being too high, exclusive to some centres, difficult to implement, or not firmly based upon the evidence (6 comments in total).
- comments on the number of thoracic surgeons potentially affecting current level 1 or 2 status, the feasibility of 3 thoracic surgeons per level one centre, and accommodation for smaller academic centres if they can document adequate outcome data (4 comments in total).
- comments that the standards around practitioner certification could include non-certified surgeons with similar training and experience as certified thoracic surgeons, that relatively few level 2 facilities would have a full-time thoracic surgeon, or that the literature supports that volume as a better indicator of outcomes than certification status (3 comments in total).
- comments that financial, organizational or manpower resources would need to be infused into the current system to achieve the standards as stated (11 comments in total).
- comment that the standards around the practice setting the relationship between level 1 and 2 centres was not explicit and that defining and implementing level 2 centres would be challenging, especially for remote populations that were geographic or volume based (7 comments in total).
- general comments included the identification of a recent article, the potential for legal risks for surgeons with a standards document, more representation from thoracic surgeons from proposed level 2 type centres, and a suggested change in the standards document title (4 comments in total).

These points were brought back to the Panel for discussion. While identifying explicit volumes for Level 1 and Level 2 centres have not been the explicit subject of study, these standards reflect the best interpretation of the available evidence. The Panel continues to support these recommendations. The remaining points revolve around the implementation of these standards. These points were brought back to the Panel for discussion. While identifying specific volumes for Level 1 and Level 2 centres have not been the explicit subject of study, these standards reflect the best interpretation of the available evidence. The Panel continues to support these recommendations. The remaining points revolve around the implementation of these standards. While an implementation plan is beyond the scope of the current document, the use of guidelines and standards is fundamental to the success of cancer Care Ontario’s quality improvement initiatives. This standards document will provide
an important source of information for regional and provincial planning of thoracic cancer surgery services.

**Report Approval Panel**

The final version of the Evidence-Based Series was submitted to the Report Approval Panel (RAP) of the PEBC for approval. The RAP approved the document but requested clarity around (i) the complexity of surgeries recommended in the Level 1 and Level 2 centres and (ii) some methodological steps (e.g., details regarding working group role, how consensus was reached, decisions regarding data synthesis and pooling). These details were added to the final document.

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</tr>
<tr>
<td>Dr. Donna Maziak</td>
<td>The Ottawa Hospital General Campus Ottawa, Ontario K1H 8L6</td>
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<td>Dr. Peter Dixon</td>
<td>Durham Regional Cancer Centre 1 Hospital Court Oshawa, Ontario L1G 2B9</td>
</tr>
<tr>
<td>Dr. Brendan Mullen</td>
<td>Mount Sinai Hospital 600 University Avenue Toronto Ontario M5G 1X5</td>
</tr>
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<td>President, Juravinski Cancer Centre 699 Concession Street Hamilton, Ontario L8V 5C2</td>
</tr>
<tr>
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<td>Research Coordinator Program in Evidence-Based Care McMaster University 1280 Main Street West, Hamilton, Ontario L8S 4L8</td>
</tr>
<tr>
<td>Dr. Kenneth Gehman</td>
<td>63 North Algoma Street Suite 410 Thunder Bay, ON P7A 4Z6</td>
</tr>
<tr>
<td>Dr. Narinder Paul</td>
<td>UHN - Princess Margaret Hospital 610 University Avenue 3-956 Toronto, Ontario M5G 2M9</td>
</tr>
<tr>
<td>Dr. Michael Humer</td>
<td>2178 Pandosy Street Kelowna, BC V1Y 158</td>
</tr>
<tr>
<td>Dr. Kevin Smith</td>
<td>CEO and President St. Joseph’s Healthcare 50 Charlton Avenue East, Hamilton, Ontario L8N 4A6</td>
</tr>
<tr>
<td>Dr. Richard Inculet</td>
<td>London Health Sciences Centre 375 South Street London, Ontario N6A 4G5</td>
</tr>
<tr>
<td>Dr. Hartley Stern</td>
<td>Provincial Head, Surgical Oncology Cancer Care Ontario The Ottawa Hospital Regional Cancer Centre 503 Smyth Road, Ottawa, Ontario K1H 1C4</td>
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<tr>
<td>Dr. Donald Jones</td>
<td>The Credit Valley Hospital 2200 Eglinton Avenue West Mississauga, ON L5M 2N1</td>
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<tr>
<td>Farrah Schwartz (Coordinator)</td>
<td>Cancer Care Ontario 620 University Avenue Toronto, Ontario M5G 2L7</td>
</tr>
<tr>
<td>Dr. Shaf Keshavjee</td>
<td>Head of Thoracic Surgery University of Toronto - Toronto General Hospital 200 Elizabeth Street Toronto, Ontario M5G 2C4</td>
</tr>
</tbody>
</table>

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Section 3: Guideline Development and External Review - Methods and Results
Evidence-Based Series #17-1 Version 2: Section 4

Thoracic Surgical Oncology Standards:
Guideline Review Summary and Review Tool

S. Sundaresan, A. E. Haynes and the Expert Panel on Thoracic Surgical Oncology

A Special Project of the Surgical Oncology Program, Cancer Care Ontario and
The Program in Evidence-Based Care, Cancer Care Ontario.
Developed by the Expert Panel on Thoracic Surgical Oncology

Review Date: March 4, 2015

The 2005 guideline recommendations are

ENDORSED

This means that the recommendations are still current and relevant for decision making.

OVERVIEW

The original version of this guidance document was released by Cancer Care Ontario’s Program in Evidence-Based Care in 2005. In November 22, 2013, this document was assessed in accordance with the PEBC Document Assessment and Review Protocol and was determined to require a review. As part of the review, a PEBC methodologist conducted an updated search of the literature. A clinical expert (SS) reviewed and interpreted the new eligible evidence and proposed the existing recommendations could be endorsed. The Expert Panel on Thoracic Surgical Oncology (the Expert Panel, see Appendix 3) endorsed the recommendations found in Section 1 (Guideline Recommendations) on March 4, 2015.

DOCUMENT ASSESSMENT AND REVIEW RESULTS

Questions Considered
What is the optimum organization for the delivery of cancer-related thoracic surgery in Ontario?
Literature Search and New Evidence

The new search (January 2004 to December 23, 2013) yielded a total of 14 publications of 11 systematic reviews and 99 publications of primary studies—most were retrospective cohort designs. The results of the included systematic reviews and primary studies can be found in the Document Review Tool.

Impact on Guideline and its Recommendations

The evidence supports the existing recommendations; specifically, the identified systematic reviews and meta-analyses provide strong evidence of a volume-outcome relationship, for both hospital and surgeon volume, in thoracic oncology surgery. Both high hospital volume and high surgeon volume are associated with lower 30-day mortality. The evidence shows a weaker link between hospital or surgeon volume and long-term survival. It should be noted that during the development of the 2005 recommendations, there was a lack of evidence for several recommendations; however, some low to moderate quality studies are now available that investigated the relationship between outcome and other variables such as, type of hospital (academic versus community, designated cancer centre versus non-designated cancer centre); type of surgeon (thoracic versus general), and; physical resources and organizational requirements (use of multidisciplinary teams and cancer conferences, and associated health care human resources such as nurses and anaesthesiologists). Although the data on these variables appear to be promising, the relationship to outcome is not as clear as that for the hospital or surgeon volume-outcome relationship.

The Expert Panel agreed that no new recommendations are required and that the 2005 recommendations cover all relevant subject areas identified in the new evidence; therefore, the Expert Panel ENDORSED the 2005 recommendations on thoracic surgical oncology standards.

Although the Expert Panel agreed that the recommendations should be endorsed, two concerns were noted.

1. That the recommendations on surgical volumes should be changed from:
   - Surgical volumes in the range of 20 esophagectomy cases per unit per year and 150 pulmonary resections per unit per year should be considered targets for Level 1 centres.
   - Surgical volumes in the range of 7 esophagectomy cases per unit per year and 50 pulmonary resections per unit per year should be considered targets for Level 2 centres.

   To:
   - Surgical volumes of a minimum of 20 esophagectomy cases per unit per year and 150 pulmonary resections per unit per year should be considered targets for Level 1 centres.
   - Surgical volumes of a minimum of 7 esophagectomy cases per unit per year and 50 pulmonary resections per unit per year should be considered targets for Level 2 centres.

The original and the revisions to the surgical volume targets are based on the expert opinion of the guideline panels. The updated literature review did not provide any new data to inform these recommendations. The Expert Panel noted that although the newly reviewed literature did not provide a basis in evidence for revising the target volume of 7 esophagectomy cases per unit per year for Level 2 centres, the literature should be monitored and the volumes should be revised as new evidence emerges.
2. That wedge resections for lung cancer were being performed outside of Level 1 and Level 2 centres in the province. After discussion, the Expert Panel believed that this is likely due to a misunderstanding of the recommendations under the subheading, “Volume of Thoracic Surgery.” The original recommendations stated that “…150 anatomic pulmonary resections per unit per year…” were required for Level 1 status and “…50 anatomic pulmonary resections per unit per year…” were required for Level 2 status. The Expert Panel noted that the original recommendations were meant to include all pulmonary resections for lung cancer, including wedge resections. The Expert Panel agreed that word “anatomic” be deleted and that this change should be explicitly noted in the original guideline recommendations.
**Document Review Tool**

<table>
<thead>
<tr>
<th>Number and title of document under review</th>
<th>EBS 17-1 - Thoracic Surgical Oncology Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Report Date</strong></td>
<td>September 9, 2005</td>
</tr>
<tr>
<td><strong>Clinical Expert</strong></td>
<td>Dr. Sudhir Sundaresan</td>
</tr>
<tr>
<td><strong>Research Coordinator</strong></td>
<td>Adam Haynes</td>
</tr>
<tr>
<td><strong>Date Assessed</strong></td>
<td>November 22, 2013</td>
</tr>
<tr>
<td><strong>Approval Date and Review Outcome (once completed)</strong></td>
<td>ENDORSED on March 4, 2014</td>
</tr>
</tbody>
</table>

**Original Question(s):**
What is the optimum organization for the delivery of cancer-related thoracic surgery in Ontario?

**Target Population:**
Not specifically stated in original guideline.

**Scope of Standards:** “The following standards, developed by the Expert Panel on Thoracic Surgical Oncology, apply to thoracic surgical oncology and include the full spectrum of multi-disciplinary assessment and treatment.”

**Study Section Criteria:**

**Inclusion Criteria:**
Reports were selected for inclusion in this systematic review of the evidence if they reported information on organizational resources relating to improved outcomes for patients undergoing cancer-related thoracic surgery. Patient-related outcomes of interest include: tumour response, local disease control, survival, adverse events, or quality of life.

Practice guidelines, meta-analyses, or systematic reviews related to the research question were also eligible for inclusion in the systematic review of the evidence.

**Exclusion Criteria:**
Articles were excluded from the systematic review of the evidence if they reported information on thoracic surgeries for tumours in locations other than the lung or esophagus, if they were published or developed prior to 1990 and/or were in a language other than English.

**Search Details:**
For the methods used to develop the literature search strategy and to screen citations, please see Appendix 1.

**Search Strategies:**
Medline (OVID) (2004 to November Week 3, 2013 [December 23, 2013]):
1. general surgery/
2. surgery/
3. surgical procedures, operative/
4. (surger$ or (surgical$ adj (procedure$ or operation$ or resect$))).ti,ab.
5. or/1-4
6. exp lung neoplasms/
7. exp pleural neoplasms/
8. exp thymus neoplasms/
9. exp thymoma/
10. exp mesothelioma/
11. (NSCLC$ or SCLC$).ti,ab.
12. ((pulmonary or lung$ or thym$ or pleural$) adj3 (cancer$ or carcininom$ or adenocarcinom$ or neoplas$ or malignan$ or tumo?r$)).ti,ab.
13. ((malignan$ adj5 pleural$ adj5 mesothelioma$) or MPMS$).ti,ab.
14. thymoma$.ti,ab.
15. esophageal neoplasms/
16. ((esophag$ or oesphag$) adj3 (cancer$ or carcinoma$ or adenocarcinom$ or neoplas$ or malignan$ or neoplas$)).ti,ab.
17. or/6-16
18. 5 and 17
19. thoracic surgery/
20. thoracotomy/
21. esophagectomy/
22. pneumonectomy/
23. esophagectom$.ti,ab.
24. oesophagectom$.ti,ab.
25. pneumonectom$.ti,ab.
26. thoracotom$.ti,ab.
27. ((esophag$ or oesphag$) adj3 (surgery or resection or operation$)).ti,ab.
28. (thorax$ adj3 (surgery or operation$ or resection$)).ti,ab.
29. (lung$ adj5 volume$ adj3 reduction$).ti,ab.
30. lobectom$.ti,ab.
31. exp lung neoplasms/su
32. exp pleural neoplasms/su
33. exp thymus neoplasms/su
34. exp thymoma/su
35. esophageal neoplasms/su
36. mesothelioma/su
37. or/19-36
38. 18 or 37
39. (volume$ adj2 (standard$ or outcome$ or mortality$ or operati$)).ti,ab.
40. (cancer adj (centre$ or center$)).ti,ab.
41. (teaching adj2 (status or hospital$)).ti,ab.
42. (designated adj (centre$ or center$ or hospital$ or site$)).ti,ab.
43. (thoracic adj2 surgeon$).ti,ab.
44. ((surgical$ or surgeon$) adj2 (volume$ or workload$ or experience$ or train$ or standard$ or requirement$ or guideline$ or qualit$ or special$ or subspecial$)).ti,ab.
45. ((hospital$ or site$ or centre$ or centre$) adj2 (volume$ or standard$ or requirement$ or guideline$ or qualit$ or special$ or subspecial$)).ti,ab.
46. ((practice$ or organi?ation$ or resource$ or train$) adj2 (requirement$ or standard$ or guideline$ or volume$ or workload$ or experience$)).ti,ab.
47. exp "outcome and process assessment (health care)"/
48. health services administration/ or "organization and administration"/ or efficiency, organizational/ or health facility administration/ or centralized hospital services/ or surgery department, hospital/ or models, organizational/ or workload/ or "delivery of health care"/ or clinical competence/ or guideline adherence/ or exp "outcome and process assessment (health care)"/ or peer review, health care/ or "professional review organizations"/ or exp program evaluation/ or exp guidelines as topic/
49. exp Hospitals/
50. multidisciplinary.ti,ab.
51. patient care team/
52. (patient adj care).ti,ab.
53. (patterns adj5 care).ti,ab.
54. or/39-53
55. 38 and 54
56. (comment or letter or editorial or note or erratum or news or newspaper article or case report).pt.
57. 55 not 56
58. limit 57 to english language
59. (2004$ or 2005$ or 2006$ or 2007$ or 2008$ or 2009$ or 201$).ed.
60. 58 and 59

EMBASE (OVID) (2004 to 2013 Week 51 [December 23, 2013]):
1. (surger$ or (surgical$ adj (procedure$ or operation$ or resect$))).ti,ab.
2. *surgery/ or cancer surgery/ or general surgery/ or thorax surgery/
3. 1 or 2
4. exp lung cancer/
5. exp pleura tumor/
6. exp thymoma/
7. malignant mesothelioma/
8. (NSCLC$ or SCLC$).ti,ab.
9. ((pulmonary or lung$ or thym$ or pleura$) adj3 (cancer$ or carcinoma$ or adenocarcinom$ or neoplas$ or malignan$ or tumor?r$)).ti,ab.
10. ((malignan$ adj5 pleura$ adj5 mesothelioma$) or MPMS$).ti,ab.
11. thymoma$.ti,ab.
12. exp esophagus tumor/
13. ((esophag$ or oesphag$) adj3 (cancer$ or carcinoma$ or adenocarcinom$ or neoplas$ or malignan$ or neoplas$)).ti,ab.
14. or/4-13
15. 3 and 14
16. thorax surgery/
17. thoracotomy/
18. esophagus resection/
19. lung resection/
20. esophagectomy.ti,ab.
21. oesophagectomy.ti,ab.
22. pneumonectomy.ti,ab.
23. thoracotomy.ti,ab.
24. ((esophagus$ or oesophagus$) adj3 (surgery$ or resection$ or operation$)).ti,ab.
25. (thorax$ adj3 (surgery$ or operation$ or resection$)).ti,ab.
26. (lung$ adj5 volume$ adj5 reduction$).ti,ab.
27. lobectomy.ti,ab.
28. exp lung cancer/su
29. exp pleura tumor/su
30. exp thymoma/su
31. malignant mesothelioma/su
32. exp esophagus tumor/su
33. or/16-32
34. 14 or 33
35. (volume$ adj2 (standard$ or outcome$ or mortality$ or operational$)).ti,ab.
36. ((surgical$ or surgeon$) adj2 (volume$ or workload$ or experience$ or training$ or standard$ or requirement$ or guideline$ or quality$ or specialty$ or subspecialty$)).ti,ab.
37. (teaching adj2 (status or hospital$)).ti,ab.
38. (cancer adj (centre$ or center$)).ti,ab.
39. (designated adj (centre$ or center$ or hospital$ or site$)).ti,ab.
40. (thoracic adj2 surgeon$).ti,ab.
41. ((surgical$ or surgeon$) adj2 (volume$ or workload$ or experience$ or training$ or standard$ or requirement$ or guideline$ or quality$ or specialty$ or subspecialty$)).ti,ab.
42. ((hospital$ or site$ or center$ or centre$) adj2 (volume$ or standard$ or requirement$ or guideline$ or quality$ or specialty$ or subspecialty$)).ti,ab.
43. ((practice$ or organization$ or resources$ or train$ or training$) adj2 (requirement$ or standard$ or guideline$ or volume$ or workload$ or experience$)).ti,ab.
44. *hospital/ or *health care facility/ or community hospital/ or general hospital/ or high volume hospital/ or low volume hospital/ or teaching hospital/
45. clinical competence/
46. patient care/ or organizational efficiency/
47. *health care organization/
48. health care facility/ or health care organization/
49. or/35-48
50. 34 and 49
51. (letter or comment or note or erratum or editorial).pt.
52. 50 not 51
53. limit 52 to english language
54. (2004$ or 2005$ or 2006$ or 2007$ or 2008$ or 2009$ or 201$).ew.
55. 53 and 54

Also searched: Cochrane library via OVID (CDSR [Nov 2013]; CCTR [Nov 2013], and DARE [4th Quarter, 2013]).

Brief Summary/Discussion of New Evidence:
A total of 19,263 citations were identified from MEDLINE, EMBASE, CDSR, CCTR, and DARE via OVID. Of those, 308 were selected for full text review. A total of 105 publications met the inclusion criteria, 4 publications were irretrievable, and 199 publications were excluded. A further 8 publications were identified from the reference lists of included studies that were not identified in the searches of MEDLINE and EMBASE (Committee for Scientific Affairs et al, Gen Thorac Cardiovasc Surg 2007;55(12):483-92; Dillman et al, J Oncol Pract 2005;1(3):84-92; Forrest et al, Br J Cancer 2005;93(9):977-8; Gordon et al, J Am Coll Surg 1999;189(1):46-56; Halm et al, Ann Intern Med 2002;137(6):511-20; Hollenbeck et al, J Clin Oncol 2007;25(1):91-6; Kee et al, Med Decis Making 2004;24(6):602-13; Murray et al, Lung Cancer 2003;24(3):283-90).

Of the 113 identified publications there were 14 publications of 11 systematic reviews. The remaining 99 publications were of primary studies. The results of the systematic reviews can be found in Table 1. The results of the 43 publications of primary studies that were not included in at least one of the identified systematic reviews can be found in Table 2. The remaining 56 primary studies were included in at least one of the identified systematic reviews—the results of those studies are not reported here separately. Appendix 2 consists of a bibliography of those studies.
Table 1. Systematic reviews meeting inclusion criteria for EBS #17-1.

<table>
<thead>
<tr>
<th>Author, year (reference)</th>
<th>Inclusion Criteria</th>
<th>Methods</th>
<th>Intervention/Comparison</th>
<th>Outcomes of Interest</th>
<th>Brief Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pieper, 2013 (1)</td>
<td>SRs investigating relationship between hospital volume and outcomes for cancer surgery</td>
<td>Lit Search: July 2012. Strategy provided in article. Searched Medline, Embase, CDSR, DARE, HTA database and websites of HTA organizations. Assessed quality using AMSTAR</td>
<td>Hospital volume (excluded studies that reported only on surgeon volume or reported only pooled data for hospital and surgeon volume combined)</td>
<td>Clinical outcomes (authors did not specify further)</td>
<td>Esophageal Cancer: 1 SR and MA: Wouters, 2012 (2)-see below 4 SRs: Gruen, 2009 (3)-see below Gandjour, 2003 A Halm, 2002 B Dudley, 2000 C</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Based on the results of the Wouters 2012 MA (see below), the authors felt that the evidence for HVH as a determinant for post-op mortality was strong; however, they noted that statistical heterogeneity was present.</td>
</tr>
<tr>
<td>Markar, 2012 (5) and Centre for Reviews and Dissemination, 2013 (6)</td>
<td>Studies of patients who had surgical treatment for esophageal cancer since the year 2000, and compared LVH to HVH (with specifically stated thresholds) for the outcomes of interest.</td>
<td>Lit search: 1966-2011. Search terms provided in article. Searched Medline, Embase and conference proceedings from several professional organizations. No formal methods for assessing quality of the included studies were reported.</td>
<td>Hospital volume: Included studies had to specifically state the volume thresholds to determine LVH and HVH.</td>
<td>Primary: In-hospital mortality; 30-day mortality. Secondary: length of hospital stay; post-operative complications.</td>
<td>Lung Cancer: 1 SR and MA: von Meyenfeldt, 2012 (4)-see below 1 SR: Halm, 2002 B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Based on the results of the von Meyenfeldt MA (see below), the authors felt that the evidence indicates that post-op mortality improved significantly in HVH, but that the evidence was less convincing for survival.</td>
</tr>
<tr>
<td>Wouters, 2012 (7)</td>
<td>Studies investigating the volume-outcome relation in</td>
<td>Lit search: January 1 1995 to July 1, 2010. Search strategy</td>
<td>Hospital volume and surgeon volume. Included studies</td>
<td>Post-op mortality and survival.</td>
<td>Hospital volume: 43 studies were included. The volume categories varied greatly between the studies.</td>
</tr>
</tbody>
</table>
### Lung Cancer

**Systematic review and meta-analysis**

| von Meyenfeldt, 2012 (4) | Studies of patients who received surgical treatment of lung cancer, and compared outcomes between providers (hospitals or surgeons with distinct volume thresholds or clearly defined specialty) | Lit Search: January 1, 1990-January 20, 2011. Search strategy provided in article. Searches Medline (PubMed) and the Cochrane Library. Study quality was assessed using the STROBE checklist, but the results were not reported. | Hospital volume, surgeon volume, surgeon specialty. Included studies had to specifically state volume thresholds for hospitals and surgeons or clearly define surgeon specialty. |

| von Meyenfeldt, 2011 (8) | | | Post-operative mortality or survival. |

19 studies were included.

**Hospital Volume:**

**Post-operative mortality:**

5 of 11 studies found a significant inverse relationship between hospital volume and 30-day or in-hospital mortality. 

- **Pooled OR** (10 studies) 0.71, 95% CI 0.62-0.81, for HVH (range >21 to >116 surgeries/year) compared to LVH (range <2 to <43 surgeries/year).

- **Survival:** 

- **Pooled HR** (7 studies) 0.93, 95% CI 0.84-1.03, for HVH (range >21 to >84 surgeries/year) compared to LVH (range <4 to <40 surgeries/year).

**Surgeon Volume:**

**Post-operative mortality:**

1 of 2 studies showed a significant result favouring
### Rouvelas, 2010 (9)

**Systematic review**

**Esophageal Cancer**

- Studies of patients with esophageal cancer who had undergone surgery as part of their treatment, defined either hospital or surgeon volume, and reported on one at least one outcome of interest.

**Lit Search:** Early 1980’s to unknown. Search terms (keywords) were provided in the article. Search Medline (PubMed), do formal methods for assessing quality of the included studies were reported.

**Hospital volume or surgeon volume.**

**In-hospital mortality, long-term prognosis, post-operative complications, HRQoL, health economy.**

- The authors did not report the total number of included studies or include a PRISMA flow diagram.

**Hospital Volume:**

- Post-operative mortality: 13 studies included.
- Post-operative complications: 12 studies included.
- Survival: 6 studies included.
- HRQoL: Two studies included.

**Surgeon Volume:**

- Post-operative mortality: 6 studies included.
- Post-operative complications: Unclear number of studies.
- Survival: No studies included.
- HRQoL: No studies included.

Note: The reporting of the number of included studies as well as data for outcomes in the included studies was inconsistent and it was not possible to determine the number of studies with statistically significant differences for any of the above outcomes.

Authors concluded that the studies to date demonstrate that higher volume centres have lower post-operative morbidity and mortality, but there is no evidence of improvement to long-term outcomes such as survival or HRQoL. Surgeon volume also has an impact on outcomes. The authors suggest that volume may be a surrogate of other variables that are related to management of patients after surgery such as MCCs, experienced surgeons, high-quality post-operative care, skilled medical staff, and a well-established process of care. There is no defined cut-off for the lowest recommended annual volume.

### Gruen, 2009 (3)

**Systematic review and meta-analysis**

**GI cancer**

- SRs, MAs, RCTs, controlled trials, comparative studies, and cohort studies including patients with GI cancers who received surgical treatment in high-volume hospitals or by high-volume surgeons.

**Lit search:** 1966-May 2007 (start date varied depending on database). Complete search strategy provided in article. Search Medline (OVID), Embase, Australasian Medical Index, Cochrane Library, EconLit, PubMed, and ISI

**Hospital volume (high vs. low) or surgeon volume (high vs. low).**

**Short-term (30-day or in-hospital) mortality and long-term mortality.**

A total of 28 studies that investigated esophageal cancer were included.

**Meta-analysis**

**Hospital Volume:**

- Short-term mortality: 16 of 26 studies demonstrated a significant difference in favour of HVH (threshold NR) compared to LVH (threshold NR).
- Pooled OR (24 studies) for effect on mortality of doubling the hospital case volume: 0.81, 95% CI 0.77-0.84, in favour of HVH (>18 surgeries/year) compared to LVH (<9 surgeries/year).
<table>
<thead>
<tr>
<th>Literature</th>
<th>Evidence Type</th>
<th>Study Design</th>
<th>Study Population</th>
<th>Search Terms</th>
<th>Study Quality</th>
<th>Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wouters, 2009 (2)</td>
<td>Systematic review</td>
<td>Esophageal Cancer</td>
<td>Studies comparing mortality rates after esophagectomy between hospitals with a lower and higher procedural volume.</td>
<td>Lit search: 1998-2008 Search terms (keywords) provided in the article.</td>
<td>Hospital volume (high vs. low).</td>
<td>A total of 24 studies investigating hospital volume-mortality were included.</td>
</tr>
<tr>
<td>Killeen, 2005 (10)</td>
<td>Systematic review</td>
<td>Cancer</td>
<td>Systematic reviews or community or population-based cohort studies including patients with cancer who received surgical treatment and compared outcomes of interest using hospital volume as the independent variable. Single-institution studies and case series were excluded.</td>
<td>Lit search: 1984-2004 Search terms (keywords) provided in the article.</td>
<td>Hospital volume (high vs. low) and surgeon volume (high vs. low).</td>
<td>Esophageal Cancer: 10 studies investigating esophageal cancer were included.</td>
</tr>
<tr>
<td>Metzger, 2004 (11)</td>
<td>Systematic review</td>
<td>and</td>
<td>No explicit inclusion criteria were reported. Studies investigating</td>
<td>Lit search: 1990-2003 Search terms (keywords) provided in the article.</td>
<td>Hospital volume (e.g., high vs. low)</td>
<td>Lung Cancer: 10 studies investigating lung cancer were included.</td>
</tr>
</tbody>
</table>

Long-term mortality:
2 of 6 studies demonstrated a significant difference in favour of HVH (volume cut-offs NR).
No meta-analysis was conducted due to the small number of studies.

Surgeon Volume:
6 of 6 studies demonstrated a significant difference in favour of high-volume surgeons (range 1 to <47 surgeries/year) compared to low-volume surgeons (range >4 to >48 surgeries/year).
No meta-analysis was conducted due to the small number of studies.

Lung Cancer:
13 studies were included and combined in a meta-analysis. No individual study results were reported.
<table>
<thead>
<tr>
<th>Study Title</th>
<th>Study Type</th>
<th>Search Strategy</th>
<th>Use of MCCs</th>
<th>Clinical decision-making, patient management, clinical outcomes</th>
<th>Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croke, 2012 (12)</td>
<td>Systematic review</td>
<td>Searched Medline</td>
<td>Lit Search: June 1950-2010</td>
<td>Use of MCCs</td>
<td>Clinical decision-making, patient management, clinical outcomes</td>
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<td>Lung Cancer</td>
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<tr>
<td>Coory, 2008 (13)</td>
<td>Systematic review</td>
<td>Searched Medline</td>
<td>Lit Search: 1984 to July 2007</td>
<td>Use of MDTs</td>
<td>Survival</td>
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<td>Lung Cancer</td>
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<tr>
<td>Esophageal Cancer</td>
<td></td>
<td>Searched Medline</td>
<td></td>
<td>Mortality: 8 studies were included in the meta-analysis. A total of 18,032 patients provided an OR of 0.43 (95% CI 0.31-0.58) for hospitals with &gt;20 esophagectomies/year compared to hospitals with ≤20 esophagectomies/year. OR&lt;1 favours HVH (i.e., reduced risk of mortality). The authors did not report a statistical test for heterogeneity.</td>
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<tr>
<td>Other</td>
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<td>Lung Cancer</td>
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</table>

**Esophageal Cancer**

Patients who had esophagectomies and compared mortality using hospital volume as the independent variable were included.

Searched Medline, Current Contents and First Search Social Abstracts.

**Mortality:**

- 8 studies were included in the meta-analysis. A total of 18,032 patients provided an OR of 0.43 (95% CI 0.31-0.58) for hospitals with >20 esophagectomies/year compared to hospitals with ≤20 esophagectomies/year. OR<1 favours HVH (i.e., reduced risk of mortality). The authors did not report a statistical test for heterogeneity.

**Other**

Croke, 2012 (12)

Systematic review

Lung Cancer

PGs, SRs, MAs, trials, or prospective or retrospective studies of the impact of MCCs on clinical decision-making and patient outcomes in patients with cancer


Use of MCCs.

Clinical decision-making, patient management, clinical outcomes

Lung Cancer:

1 SR:

Coory, 2008 (13)

Assessed the effectiveness of MCCs in lung cancer. 16 studies met the inclusion criteria, of which 2 reported an improvement in survival in favour of MCC. – See below

3 prospective studies:

- Leo, 2007
  - In 344 patients, discussion at MCCs led to discordance in 15 cases (4.4%), with a non-significant trend to shorter survival being associated with that discordance (p=0.07).
- Forrest, 2005
  - Compared survival before and after implementation of MCC, and found that median survival increased after implementation (before, 3.2 months vs. after, 6.6 months; p<0.002)
- Kee, 2004
  - In 50 patients, MCCs did not improve the overall quality of clinical decision-making.

The authors concluded that the published literature supports that MCCs lead to changes in diagnoses and physician management decisions—for all cancers. The authors also stated that no strong prospective evidence yet exists to suggest that MCCs improve patient outcomes.

Coory, 2008 (13)

Systematic review

Lung Cancer

Any study that mentioned a team working among specialists with diagnostic and therapeutic intent, where the members met at a specified time, either in person or by video or teleconferencing, to discuss the diagnosis and management of patients with suspected lung cancer.


Use of MDTs

Survival

Identified 16 studies:

1 RCT Murray, 2003:

Compared rapid assessment (CT scan, tissue biopsy then review by MDT after 3 working days) to standard care (investigated at local clinics under the care of a specialist lung cancer physician) in 88 patients with suspected lung cancer. The authors found no statistically significant difference in 2-year survival between the two groups (33% vs. 40%, MDT vs. non-MDT; p=0.7).

7 Before-and-After Studies:

- 4 of these measured survival, of which only two found a statistically significant difference:
  - Price, 2002:
    - 1-year survival increased from 18.3% to 23.5% after introduction of MDTs and site specialization (statistically significant at p=0.049). NOTE: this is an abstract-only publication that investigated the affect of MDTs on use of radiotherapy.
  - Forrest, 2005:
    - Median survival increased from 3.4 months to 6.6 months after introduction of MDT, p<0.001.
    - And 2 studies did not find a statistically significant difference:
      - Martin-Ucar, 2004:
        - 1-year survival was similar before (63%) and after
In the multivariate model, volume was analyzed as a continuous variable.

In-hospital mortality, LOS

Pulmonary lobectomies: 19,732 patients. Pre-operatively, 82.8% had a diagnosis of cancer.

In-hospital mortality:

1999: 3.1% vs. 2007: 1.95%
Unadjusted analysis: 45% relative risk reduction (95% CI 21-61; p=0.001) over the study period.
Risk-adjusted analysis (gender, age, Charlson index): 15% relative risk reduction (95% CI 9-19; p=<0.0001) in in-hospital mortality for every 20 additional cases performed per hospital.

Within-hospital changes in volume:
-5% relative decrease in mortality for each additional 20 cases performed in a given hospital (95% CI 6 to -18; p=0.39).

LOS:
1999: 10.4 days (SD 12.2 days) vs. 2007: 8.9 days (SD 10.1 days).
Unadjusted analysis: 19% relative risk reduction (95% CI 12-25; p=0.0001) over the study period.
Risk-adjusted analysis (gender, age, Charlson index): 5% relative risk reduction (95% CI 3-7; p<0.001) in LOS for every 20 additional cases performed per hospital.

Within-hospital changes in volume:
4% relative decrease in LOS for each additional 20 cases performed within a given hospital (95% CI 1-6).

Table 2. Primary studies meeting inclusion criteria for EBS #17-1.

<table>
<thead>
<tr>
<th>Author, year, etc.</th>
<th>Procedure and population</th>
<th>Methods</th>
<th>Intervention</th>
<th>Outcomes of interest</th>
<th>Brief results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finley, 2010</td>
<td>Patients aged 18 years and older who underwent pulmonary lobectomy from 1999 to 2007 in Canada</td>
<td>Retrospective cohort from the Canadian Institute for Health Information Discharge Abstract Database. Compared LOS and in-hospital mortality by hospital volume (both between and within hospitals). In-hospital mortality analyzed by random effects logistic regression and LOS analyzed by random effects linear regression of log-transformed LOS. An unadjusted regression was performed to examine trends in outcomes over time. The effect of annual hospital volume on outcomes was examined by modeling yearly hospital volume by LOS and in-hospital mortality and by adjusting for calendar year, gender, age, Charlson comorbidity</td>
<td>In the multivariate model, volume was analyzed as a continuous variable.</td>
<td>In-hospital mortality, LOS</td>
<td>Pulmonary lobectomies: 19,732 patients. Pre-operatively, 82.8% had a diagnosis of cancer.</td>
</tr>
</tbody>
</table>

Notes: GI=gastrointestinal; HR=hazard ratio; HRQoL=health-related quality-of-life; HVH=high-volume hospital; LOS=length of hospital stay; LVH=low-volume hospital; MA=meta-analysis; MCC=multi-disciplinary cancer conference; MDT=multi-disciplinary team; OR=odds ratio; PG=practice guideline; SR=systematic review.

1This systematic review was excluded as the literature search included studies prior to 1990: Gandjour A, Bannenberg A, Lauterbach KW. Threshold volume associated with higher survival in health care. A systematic review. Med Care. 2003;41(10):1129-41.

2This systematic review was not reported further as it was published prior to the cutoff date of the literature search in the original 17-1 guideline: Halm EA, Lee C, Chassin MR. Is volume related to outcome in health care? A systematic review and methodologic critique of the literature. Ann Intern Med. 2002;137(6):511-20.

3This systematic review was excluded as the literature search included studies prior to 1990: Dudley RA, Johansen KL, Brand R, Rennie DJ, Milstein A. Selective referral to high-volume hospitals. Estimating potentially avoidable deaths. JAMA. 2000;283(9):1159-66.

4This primary study was not included in Table 2 below as it was included in a published systematic review. See Appendix 1 for a complete bibliography of primary studies that were included in at least one of the systematic reviews in Table 1.

5This study was excluded from the 17-1 update as it was included in the original 17-1 guideline: Martin-Ucar AE, Waller DA, Atkins JL, Swinson D, O'Byrne KJ, Peake MD. The beneficial effects of specialist thoracic surgery on the resection rate for non-small-cell lung cancer. Lung Cancer. 2004 Nov;46(2):227-32.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Type of Cancer</th>
<th>Study Design</th>
<th>Follow-up Period</th>
<th>Outcomes</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kozower, 2011</td>
<td>(15)</td>
<td>Lung</td>
<td>Retrospective cohort from the HCUP-NIS (U.S.) comparing inpatient mortality by hospital volume. Hierarchical generalized linear models, adjusted by patient age, gender, and comorbid disease: 3 models: 1) volume as linear effect; 2) volume as nonlinear effect, restricted cubic spline; 3) volume as nonlinear effect, quintiles.</td>
<td>2007</td>
<td>Lung resections: 7908 discharge records representing 40,460 lung cancer resections in the weighted data set. Inpatient mortality: Linear effect: OR: 1.01 95% CI 1.00-1.02 Non-linear, restricted cubic splines: OR: 1.89 95% CI 0.00-99.9 Non-linear, quintiles: 1-2 vs. &gt;24: OR 3.52 95% CI 0.92-13.52 3-6 vs. &gt;24: OR 0.85 95% CI 0.23-3.14 7-12 vs. &gt;24: OR 0.82 95% CI 0.20-3.30 13-23 vs. &gt;24: OR 0.37 95% CI 0.10-1.41</td>
<td></td>
</tr>
<tr>
<td>Luchtenborg, 2013</td>
<td>(16)</td>
<td>Lung</td>
<td>Retrospective cohort from the National Cancer Data Repository (NCDR) in England from 2004-2008 comparing survival between hospital volume quintiles. Multivariable Cox proportional hazards regression analyses adjusted by sex, age, SES-deprivation score, Charlson comorbidity, and volume quintile. A shared frailty Cox model was used, with hospital as a random effect to account for the risk of death varying between groups of patients treated within a given hospital.</td>
<td>2004-2008 in England.</td>
<td>Lung resections: &lt;70: 2582 patients in 44 hospitals 70-99: 2662 patients in 13 hospitals 100-129: 2378 patients in 11 hospitals 130-149: 2651 patients in 9 hospitals ≥150: 2589 patients in 6 hospitals Multivariable Cox model: 70-99 vs. &lt;70: HR 0.90 95% CI 0.83-0.98 100-129 vs. &lt;70: HR 0.93 95% CI 0.85-1.01 130-149 vs. &lt;70: HR 0.91 95% CI 0.83-0.98 ≥150 vs. &lt;70: HR 0.83 95% CI 0.76-0.91 Shared frailty Cox model: 70-99 vs. &lt;70: HR 0.86 95% CI 0.77-0.97 100-129 vs. &lt;70: HR 0.90 95% CI 0.79-1.02 130-149 vs. &lt;70: HR 0.89 95% CI 0.78-1.02 ≥150 vs. &lt;70: HR 0.78 95% CI 0.67-0.90</td>
<td></td>
</tr>
<tr>
<td>Otake, 2011</td>
<td>(17)</td>
<td>Lung</td>
<td>Cross-sectional survey of 926 and 855 teaching hospitals in 2007 and 2008 in Japan comparing in hospital mortality and post-operative LOS by hospital volume categories. In-hospital mortality was compared between each subcategory by chi-squared test. Logistic regression, adjusted for sex, age, and comorbidities, was used to determine effect of hospital volume on in-hospital mortality, post-operative LOS.</td>
<td>July and December in 2007 and 2008.</td>
<td>Lobectomies: Low: 5013 patients in 327 hospitals Medium-low: 5127 patients in 87 hospitals Medium-high: 4856 patients in 55 hospitals High: 4835 patients in 27 hospitals In-hospital mortality: Low: 0.94% Medium-low: 0.62% Medium-high: 0.72% High: 0.48% P=0.044 Logistic regression: Medium-low vs. low: OR: 0.68 95% CI 0.43-1.08 Medium-high vs. low: OR: 0.82 95% CI 0.53-1.28 High vs. low: OR: 0.60 95% CI 0.36-0.99 Post-operative LOS: Mean days:</td>
<td></td>
</tr>
</tbody>
</table>
### Section 4: Document Review Summary and Review Tool

**Lung Cancer**

<table>
<thead>
<tr>
<th>Reference</th>
<th>Study Details</th>
<th>Methods</th>
<th>Results</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Park, 2011 (19)</td>
<td></td>
<td></td>
<td></td>
<td>VATS lobectomy: 1,523 cases. HVH: 722 cases LVH: 801 cases</td>
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<tr>
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<td>Median LOS: Unadjusted: HVH: 4 days vs. LVH: 6 days; p=0.001 Adjusted OR: -0.90 95% CI -1.67 to -0.13; p=0.022</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td>Complications: Unadjusted: HVH 38.1% vs. LVH: 38.5%; p=0.92</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mortality: Unadjusted: HVH 1.4% vs. LVH: 1.6%; p=0.83</td>
</tr>
<tr>
<td>Smithers, 2013 (20) abstract</td>
<td>Patients who underwent surgical treatment for lung cancer from 2001-2010. This study also included patients who had surgery for pancreatic cancer or gastrointestinal cancer.</td>
<td>Retrospective cohort from 2001-2010 drawn from patients treated at hospitals in Queensland Australia comparing 30-day postoperative mortality between low and high volume hospitals. Proportional hazards regression analysis adjusted by demographic and clinical characteristics.</td>
<td>Volume cutoff (annual): The median annual hospital volume for lung resections was used as the cutoff for HVH vs. LVH. The median was NR.</td>
<td>30-day postoperative mortality</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lung resections: 2570 cases 30-day postoperative mortality: HR: 4.8 95% CI 1.5-15.0, for LVH vs. HVH.</td>
</tr>
<tr>
<td>Yun, 2012 (21)</td>
<td>Patients aged ≥20 years with lung cancer who underwent surgical treatment from 2001 through 2005. This study also included patients who had surgical treatment for cancer of the stomach, colon, rectum, pancreas, or breast.</td>
<td>Retrospective cohort from 2001 through 2005 with follow-up data through 2006 from the Korea Central Cancer Registry database and the National Health Insurance database in Korea. Compared overall survival by hospital volume. Multivariable Cox proportional hazards modeling to assess</td>
<td>Volume cutoff (annual): Low: NR Medium: NR High: NR</td>
<td>5-year survival</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lung resections: Number of cases: NR 5-year survival: 50.1% for all patients with a lung resection. Unadjusted HR: 1.69 95% CI 1.56-1.84 for low or medium volume hospitals compared to high volume hospitals. Adjusted HR: 1.60 95% CI 1.47-1.74 for low or medium volume hospitals compared to high volume hospitals.</td>
</tr>
<tr>
<td>Study</td>
<td>Patients Description</td>
<td>Methodology</td>
<td>Volume cutoffs (annual):</td>
<td>Inpatient mortality</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Learn, 2010 (22)</td>
<td>Patients aged 18 years or older who underwent esophagectomy for esophageal cancer or major lung resection for lung cancer in the U.S. This study also included pancreatic cancer and gastric cancer.</td>
<td>Retrospective cohort from the HCUP-NIS (U.S.) from 1997 to 2006 comparing inpatient mortality between time periods, by hospital volume, by hospital type (teaching vs. non-teaching). Logit-linked generalized estimating equations adjusted using Elixhauser comorbidity index.</td>
<td>Lung: High: &gt;33 Medium: 17-33 Low: 1-16 Esophageal: High: &gt;6 Medium: 3-6 Low: 1-2</td>
<td>Inpatient mortality</td>
</tr>
<tr>
<td>Allareddy, 2010 (23)</td>
<td>Patients who underwent esophagectomy in the U.S. This study also included other surgical procedures.</td>
<td>Retrospective cohort study from the HCUP-NIS from 2000-2003 comparing complications and in-hospital mortality by hospital volume categories. Multivariable logistic regression models adjusting for age, sex, admission type, comorbid severity, primary diagnosis, extent/type of primary procedure, year of procedure, hospital teaching status and bed size. A second model for in-hospital mortality was also used that used the above plus adjusted for the effect of complications that were significantly associated with in-hospital mortality at the p&lt;0.10 level.</td>
<td>Leapfrog Group cutoff: HVH: ≥13 LVH: &lt;13</td>
<td>In-hospital mortality, complications. Esophagectomies: 2473 procedures in 555 hospitals. Complications: HVH vs. LVH: OR 1.03 95% CI 0.82-1.29 In-hospital mortality: OR (not adjusted for complications): 0.54 95% CI 0.33-0.86 OR (adjusted for complications): 0.53 95% CI 0.35-0.82</td>
</tr>
<tr>
<td>Finley, 2011 (24)</td>
<td>Patients aged 18 years and older who underwent esophagectomies from 1998 to 2007 in Canada.</td>
<td>Retrospective cohort from the Canadian Institute for Health Information Discharge Abstract Database. Compared LOS and in-hospital mortality, LOS</td>
<td>In the multivariate model, volume was analyzed as a continuous variable.</td>
<td>In-hospital mortality, LOS Esophagectomies: 6985 patients. In-hospital mortality: 1998: 9.1% (95% CI 6.9% to 11.8%) vs. 2007: 3.6% (95% CI 2.4% to 5.1%)</td>
</tr>
</tbody>
</table>
### Section 4: Document Review Summary and Review Tool

#### Table 1: Patient Characteristics and Study Design

| Study | Patients with esophageal cancer who received surgical treatment in the Netherlands from 1989 through 2009. This study also included patients with gastric cancer surgeries. | Retrospective cohort from the Netherlands Cancer Registry comparing post-op mortality and survival by annual hospital volume for esophagectomy. Survival and 6-month mortality analyzed by Cox regression stratified for hospital volume and adjusted for factors used to analyze changes over time and for clustering of deaths within hospitals. | Volume cutoffs (annual):  
Very low: 1-5  
Low: 6-10  
Medium: 11-20  
High: ≥21 | Survival, 6-month mortality. | Unadjusted analysis: 64% decrease in the odds of in-hospital mortality (95% CI 51% to 74%; p=0.0001) over the study period.  
Risk-adjusted analysis (gender, age, Charlson index):  
15% relative decrease (95% CI 6% to 23%; p=0.001) in in-hospital mortality for every 10 additional cases performed per hospital.  
LVH (≤6 procedures per year): 9.8% (95% CI 8.3% to 11.4%)  
HVH (>20 procedures per year): 4.8% (95% CI 4.1% to 5.6%)  
**Within-hospital changes in volume:**  
4% relative decrease in mortality for each incremental increase in volume of 10 cases above average within a given hospital per year (95% CI -12% to 18%; p=0.58).  
**LOS:**  
1998: 24.2 days (SD 21.9 days) vs. 2007: 17.3 days (SD 21.9 days).  
Unadjusted analysis: 38% decrease in the expected LOS (95% CI 34% to 43%; p<0.0001) over the study period.  
Risk-adjusted analysis (gender, age, Charlson index):  
10% increase in LOS (95% CI 2% to 19%; p=0.01) for every 10 additional cases performed per hospital.  
**Within-hospital changes in volume:**  
2% relative increase in LOS for each incremental increase in volume of 10 cases above average within a given hospital per year (95% CI -2% to 5%; p=0.34). |  
| Esophageal Cancer |  
Dikken, 2012 (25) | Patients with esophageal cancer who received surgical treatment in the Netherlands from 1989 through 2009. This study also included patients with gastric cancer surgeries. | Retrospective cohort from the Netherlands Cancer Registry comparing post-op mortality and survival by annual hospital volume for esophagectomy. Survival and 6-month mortality analyzed by Cox regression stratified for hospital volume and adjusted for factors used to analyze changes over time and for clustering of deaths within hospitals. | Volume cutoffs (annual):  
Very low: 1-5  
Low: 6-10  
Medium: 11-20  
High: ≥21 | Survival, 6-month mortality. | Unadjusted analysis: 64% decrease in the odds of in-hospital mortality (95% CI 51% to 74%; p=0.0001) over the study period.  
Risk-adjusted analysis (gender, age, Charlson index):  
15% relative decrease (95% CI 6% to 23%; p=0.001) in in-hospital mortality for every 10 additional cases performed per hospital.  
LVH (≤6 procedures per year): 9.8% (95% CI 8.3% to 11.4%)  
HVH (>20 procedures per year): 4.8% (95% CI 4.1% to 5.6%)  
**Within-hospital changes in volume:**  
4% relative decrease in mortality for each incremental increase in volume of 10 cases above average within a given hospital per year (95% CI -12% to 18%; p=0.58).  
**LOS:**  
1998: 24.2 days (SD 21.9 days) vs. 2007: 17.3 days (SD 21.9 days).  
Unadjusted analysis: 38% decrease in the expected LOS (95% CI 34% to 43%; p<0.0001) over the study period.  
Risk-adjusted analysis (gender, age, Charlson index):  
10% increase in LOS (95% CI 2% to 19%; p=0.01) for every 10 additional cases performed per hospital.  
**Within-hospital changes in volume:**  
2% relative increase in LOS for each incremental increase in volume of 10 cases above average within a given hospital per year (95% CI -2% to 5%; p=0.34). |  
| Esophageal Cancer |  
Dikken, 2011 (26) |  
| Esophageal Cancer |  
2-year survival was analyzed by Cox regression adjusting for sex, age, morphology, stage,  
Comorbidity index. | Volume cutoffs (annual):  
1-10, 11-20, 21-30, 31-40, ≥41 | 2-year survival, 30-day mortality. |  
| Esophagectomies:  
Very low: 2914 cases  
Low: 2695 cases  
Medium: 1494 cases  
High: 2922 cases  
3-year Survival:  
Low vs. Very low: HR 1.01 95% CI 0.94-1.10  
Medium vs. Very low: HR 0.90 95% CI 0.81-0.99  
High vs. Very low: HR 0.77 95% CI 0.70-0.85  
6-month Mortality:  
Low vs. Very low: HR 0.90 95% CI 0.78-1.03  
Medium vs. Very low: HR 0.78 95% CI 0.62-0.97  
High vs. Very low: HR 0.48 95% CI 0.38-0.61 |  
| Esophagectomies:  
10,854 total cases (# of cases NR by volume cutoff)  
30-day mortality (10,854 cases):  
11-20 vs. 1-10: OR 0.82 95% CI 0.61-1.11  
21-30 vs. 1-10: OR 0.68 95% CI 0.50-0.93  
31-40 vs. 1-10: OR 0.58 95% CI 0.39-0.85  
≥41 vs. 1-10: OR 0.55 95% CI 0.42-0.72  
2-year mortality (3942 cases):  
11-20 vs. 1-10: HR 0.92 95% CI 0.78-1.08  
21-30 vs. 1-10: HR 0.84 95% CI 0.63-1.11  
31-40 vs. 1-10: HR 0.77 95% CI 0.63-0.94 |
and clustering of patients within hospitals. Patients from England were excluded from the 2-year survival analysis as data on stage were not available.

<table>
<thead>
<tr>
<th>Year</th>
<th>Authors</th>
<th>Patients</th>
<th>Study Design</th>
<th>Volume cutoffs (annual):</th>
<th>Hospital mortality (defined as 30-day or in-hospital mortality), Complications, Failure to rescue (death in a patient with 1 or more complications)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>Ghaferi (29)</td>
<td>Patients aged 65 to 99 years who underwent esophagectomy in U.S.</td>
<td>Retrospective cohort from the Medicare Provider Analysis and Review files from 2005 to 2007 comparing hospital mortality between very low and very high volume hospitals. Logistic regression adjusted using patient age, sex, race, urgency of operation, and comorbidities.</td>
<td>Very low: 1-4, Very high: 15-102</td>
<td>HR 0.79 (95% CI 0.66-0.96)</td>
</tr>
<tr>
<td>2012</td>
<td>Kozower (30)</td>
<td>Patients who underwent esophagectomy for esophageal cancer in 2007.</td>
<td>Retrospective cohort from the HCUP-NIS (U.S.) comparing inpatient mortality by hospital volume. Hierarchical generalized linear models, adjusted by patient age, gender, and comorbid disease: 3 models: 1) volume as linear effect; 2) volume as nonlinear effect, restricted cubic spline; 3) volume as nonlinear effect, quintiles.</td>
<td>Very LVH: 4625 cases, Very HVH: 4213 cases</td>
<td>HR 0.79 (95% CI 0.66-0.96)</td>
</tr>
</tbody>
</table>

**Kozower, 2012 (30) Esophageal Cancer**

Patients who underwent esophagectomy for esophageal cancer in 2007. This study also included patients who underwent gastrectomy or pancreatectomy.

<table>
<thead>
<tr>
<th>Year</th>
<th>Authors</th>
<th>Patients</th>
<th>Study Design</th>
<th>Volume cutoffs (annual):</th>
<th>Hospital mortality (defined as 30-day or in-hospital mortality), Complications, Failure to rescue (death in a patient with 1 or more complications)</th>
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<tbody>
<tr>
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<td>Kozower (30)</td>
<td>Patients who underwent esophagectomy for esophageal cancer in 2007.</td>
<td>Retrospective cohort from the HCUP-NIS (U.S.) comparing inpatient mortality by hospital volume. Hierarchical generalized linear models, adjusted by patient age, gender, and comorbid disease: 3 models: 1) volume as linear effect; 2) volume as nonlinear effect, restricted cubic spline; 3) volume as nonlinear effect, quintiles.</td>
<td>Very LVH: 4625 cases, Very HVH: 4213 cases</td>
<td>HR 0.79 (95% CI 0.66-0.96)</td>
</tr>
<tr>
<td>Study</td>
<td>Participants</td>
<td>Methodology</td>
<td>Volume cutoff (annual)</td>
<td>LOS, 30-day mortality</td>
<td>Prolonged LOS (greater than 14 days), 90-day mortality</td>
</tr>
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</tr>
<tr>
<td>Reidy, 2012 (33)</td>
<td>Patients who underwent minimally invasive esophagectomy at either one HVH or one LVH, but by the same surgical team.</td>
<td>Retrospective cohort study from 2009-2010 at two centres in the U.S. The methods of analysis were NR.</td>
<td>HVH: NR LVH: NR</td>
<td>HVH: 127 cases LVH: 37 cases</td>
<td>LOS (median): HVH: 7 days vs. LVH: 7 days; p=0.525</td>
</tr>
<tr>
<td>Rosati, 2012 (34)</td>
<td>Patients who underwent esophagectomies from 2005-2011.</td>
<td>Retrospective cohort study from 2009-2010 using data from hospitals in the Lombardy Region in Italy comparing 30-day post-operative mortality and hospital stay between hospital volume categories. Logistic regression model used to estimate association between hospital volume and outcomes (adjusted using age, sex and comorbidity index).</td>
<td>High: ≥150 Medium: 50-149 Low: ≤49</td>
<td>High: 4 hospitals, cases NR Medium: 9 hospitals, cases NR Low: 98 hospitals, cases NR Total: 2801 cases</td>
<td>Length of hospital stay: High: median 20 days Medium: median 25 days Low: median 25 days</td>
</tr>
<tr>
<td>Varghese, 2011 (35)</td>
<td>Patients aged ≥18 years who underwent esophagectomy, esophagogastrectomy not otherwise specified, intrathoracic esophagogastrectomy, antesternal esophagogastrectomy, or partial gastrectomy with anastomosis to esophagus from 2000-2007 in Washington State, U.S.</td>
<td>Retrospective cohort from the Washington State Comprehensive Hospital Abstract Reporting System database (Veterans Affairs and U.S. Military hospitals) from 2000-2007. Compared LOS, prolonged LOS, and 90-day mortality by hospital volume category. Logistic regression models to examine relationship between hospital volume and binary outcomes. Adjusted for clustering at hospital level and by age, sex, Charlson index, indication for resection (benign vs. malignant), insurance status, and calendar year.</td>
<td>HVH: ≥13 LVH: &lt;13</td>
<td>Esophageal resections: HVH: 838 cases in 5 hospitals. LVH: 514 cases in 40 hospitals.</td>
<td>Prolonged LOS: Adjusted OR: 0.55 95% CI 0.43-1.00 for HVH vs. LVH. 90-day mortality: Adjusted OR: 0.50 95% CI 0.27-0.91 for HVH vs. LVH.</td>
</tr>
<tr>
<td>Massarweh, 2011 (36)</td>
<td>Patients aged ≥18 years who underwent esophagectomy between January 1, 1994 and December 31, 2007 in Washington State, U.S. This study also included patients who underwent esophagectomy between January 1, 1994 and December 31, 2007 in Washington State, U.S.</td>
<td>Retrospective cohort from the Washington State Comprehensive Hospital Abstract Reporting System (CHARS) database from 1994 to 2007. The cohort was split by Leapfrog group cutoff was used: HVH: ≥13 LVH: &lt;13</td>
<td>HVH: ≥13 LVH: &lt;13</td>
<td>30-day and 90-day mortality, 30-day postoperative complications.</td>
<td>Esophageal resections: HVH: 685 resections in 2-4 hospitals (# varied by year). LVH: 486 resections; # hospitals: NR.</td>
</tr>
</tbody>
</table>

artery, bypass, carotid endarterectomy, colon resection, and pancreatic resection. adjusted by patient characteristics.
included patients who underwent pancreatic resection or abdominal aortic aneurysm repair. into 2 timeframes: 1) patients treated from 1994-2000 where no Leapfrog threshold existed; or, 2) patients treated from 2001-2007 where the Leapfrog threshold existed. Compared mortality (30-day and 90-day) and postoperative complications for patients treated in hospitals meeting Leapfrog Group volume threshold for esophageal resections compared to patients treated in hospitals that did not meet the threshold.

Adjusted 90-day mortality: HVH: 6.4% vs. LVH: 10.7%; p=0.004
Adjusted 30-day complications: HVH: 49.1% vs. LVH: 41.6%; p=0.04

2001-2007 Timeframe:
HVH: 583 resections in 2-6 hospitals (# varied by year).
LVH: 845 resections; # hospitals: 12.

Adjusted 30-day mortality:
HVH: 4.8% vs. LVH: 7.8%; p=0.30
Adjusted 90-day mortality:
HVH: 6.3% vs. LVH: 9.8%; p=0.23
Adjusted 30-day complications:
HVH: 44.2% vs. LVH: 43.4%; p=0.10

Sundaresan, 2013 (37)
Lung Cancer and Esophageal Cancer
Patients who underwent thoracic surgeries for cancer (esophagectomy or pulmonary resection) from 2003-2011 in Ontario.
Retrospective cohort from the Canadian Institute for Health Information (CIHI) Discharge Abstract Database comparing 30-day mortality rates before (2004-2005) and after (2009-2011) regionalization of thoracic cancer surgical procedures. Unpaired t test, \( \alpha = 0.05 \).

30-day mortality:
Lung resections:
2004-2005: 3.6% vs. 2009-2011: 3.0%; p=0.32

Regionalization:
In 2004, 46 hospitals performed thoracic surgical oncology procedures.
By late 2010, 15 hospitals performed thoracic surgical oncology procedures.
Level I centre (n=13): 150 lung resections/year & 20 esophagectomy/year
Level II centre (n=2): 20 lung resections/year & 7 esophagectomy/year

Bilimoria, 2010 (38)
Lung Cancer or Esophageal Cancer
Patients who underwent surgical treatment for lung cancer or esophageal cancer in the U.S. from 2003-2005. This study also included bladder, breast, colon, gastric, liver, melanoma, ovarian, pancreas, Retrospective cohort from the National Cancer Database (U.S.) from 2003-2005 comparing 60-day perioperative mortality by hospital type. Cox proportional hazards regression was used to evaluate Hospital type:
Specialized centres (SC): NCI-designated cancer centre and cancer site-specific hospitals in the highest procedure volume quintile (cutoffs NR).

60-day perioperative mortality:
Lung Cancer:
2004-2005: 77561 patients:
SC: 23.5%; Other: 20.5%; CH: 56.0%
1350 hospitals:
SC: 5.8%; Other: 16.1%; CH: 78.1%

60-day perioperative mortality:
High-risk patients (age \( \geq 75 \) years or Charlson score \( \geq 2 \)):
61860 patients
Unadjusted rate:
<table>
<thead>
<tr>
<th>Cheung, 2010 (39)</th>
<th>Patients with esophageal cancer who received surgical treatment in the state of Florida between 1998-2002. This study also included patients with esophageal cancer treated with other modalities.</th>
<th>Retrospective cohort from the Florida Cancer Data System (FCDS) and the Agency for Health Care Administration datasets, comparing survival between teaching hospitals and non-teaching hospitals in the state of Florida. Kaplan-Meier survival curves compared using the log-rank test.</th>
<th>Hospital type: Teaching: Recognized as a teaching institution by the Association of American Medical Colleges (AAMC). Non-teaching: Not recognized by the AAMC.</th>
<th>Overall survival, 90-day mortality</th>
<th>Esophageal resections: Teaching: 201 cases Non-teaching: 770 cases</th>
<th>Median overall survival: Teaching: 47.3 months vs. Non-teaching: 20.5 months; ( p &lt; 0.001 )</th>
<th>90-day mortality: Teaching: 4.1% vs. Non-teaching: 11.2%; ( p &lt; 0.001 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dikken, 2012</td>
<td>Patients with esophageal cancer treated with other modalities.</td>
<td>Retrospective cohort</td>
<td>Hospital type: 3-month</td>
<td>Esophagectomies:</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
### Section 4: Document Review Summary and Review Tool

#### Esophageal Cancer

<table>
<thead>
<tr>
<th>Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dikken, 2013 (40)</td>
<td>Patients who received an esophagectomy from 1989-2009. This study also included patients with gastric cancer.</td>
</tr>
<tr>
<td>Merkow, 2013 (42)</td>
<td>Patients who underwent esophageal resection between 2007-2011 in the U.S. This study also included patients who underwent colorectal or pancreatic surgeries for cancer.</td>
</tr>
<tr>
<td>Boudourakis, 2009 (43)</td>
<td>Patients ≥18, esophagectomy or lung lobectomy with primary diagnosis of cancer</td>
</tr>
</tbody>
</table>

#### Esophageal Cancer and Lung Cancer

<table>
<thead>
<tr>
<th>Volume cutoff:</th>
<th>Lung Cancer:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low: ≤4</td>
<td>High: ≥12</td>
</tr>
<tr>
<td>Esophageal Cancer:</td>
<td>Low: ≤22</td>
</tr>
</tbody>
</table>

#### Surgeon volume

<table>
<thead>
<tr>
<th>Surgeon volume</th>
<th>Inpatient mortality, LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td># of patients:</td>
<td>1999: 221</td>
</tr>
<tr>
<td>Unadjusted outcomes</td>
<td>Mortality (%)</td>
</tr>
</tbody>
</table>

#### Esophageal Resections:

<table>
<thead>
<tr>
<th>Hospital type:</th>
<th>30-day mortality, 30-day morbidity, prolonged LOS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCI-CC: National Cancer Institute Cancer Centre.</td>
<td></td>
</tr>
<tr>
<td>Non-NCI-CC: non-National Cancer Institute Cancer Centre.</td>
<td></td>
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</tbody>
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#### 30-day mortality:

<table>
<thead>
<tr>
<th>Hospital type:</th>
<th>Unadjusted OR: 0.79; 95% CI 0.56-1.10</th>
<th>Adjusted OR: 0.88; 95% CI 0.55-1.41</th>
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#### 3-year survival:

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<tr>
<th>Hospital type:</th>
<th>Unadjusted OR: 0.86; 95% CI 0.70-1.05</th>
<th>Adjusted OR: 0.69; 95% CI 0.51-0.92</th>
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### Surgeon other (e.g., Training)

<table>
<thead>
<tr>
<th>Surgeon</th>
<th>Study Year</th>
<th>Study Details</th>
<th>Data Source</th>
<th>Surgeon Type</th>
<th>End Points</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ellis, 2011</td>
<td>Lung Cancer</td>
<td>Patients with lung cancer who received wedge resection, segmentectomy, lobectomy, or pneumonectomy. Retrospective cohort from the Nationwide Inpatient Sample database (U.S.) from 1998 to 2007. Multivariate analysis using binary logistic regression models.</td>
<td>Nationwide Inpatient Sample database (U.S.)</td>
<td>General thoracic surgeon (GTS): &gt;75% of procedures were general thoracic operations and ≤10% of procedures were cardiac operations. Cardiac surgeon (CS): &gt;10% of procedures were cardiac operations. General surgeon (GS): &lt;75% of procedures were general thoracic operations and &lt;10% of procedures were cardiac operations.</td>
<td>In-hospital mortality, post-op complications.</td>
<td>GS vs. GTS: OR 1.55, 95% CI 1.20–2.01, p&lt;0.001</td>
</tr>
<tr>
<td>Freeman, 2013</td>
<td>Lung Cancer</td>
<td>Patients with NSCLC who received a lobectomy. Retrospective cohort from the Premier inpatient database (U.S.) from 2005-2009. Data collected from hospitals with at least 50 lobectomies for NSCLC during 2005-2009. Multiple logistic regression analysis adjusted for clustering or nesting at the hospital level and adjustment for patient age and Charlson comorbidity index score.</td>
<td>Premier inpatient database (U.S.)</td>
<td>General surgeon (GS) vs. thoracic surgeon (TS): classification based on surgeons’ national provider numbers and board certification status.</td>
<td>Operative mortality (death after surgery but before discharge from hospital or within 30-days of surgery); morbidity.</td>
<td>Data from 54 hospitals in 31 states: GS: 2823 lobectomies by 46 GS TS: 3653 lobectomies by 29 TS</td>
</tr>
<tr>
<td>Gopaldas, 2013</td>
<td>Lung Cancer</td>
<td>Patients who underwent esophagectomy</td>
<td>Nationwide Inpatient Sample</td>
<td>Thoracic surgeon</td>
<td>In-hospital mortality, failure to rescue</td>
<td>Control: 15,728 cases</td>
</tr>
<tr>
<td>Gopaldas, 2011</td>
<td></td>
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<tr>
<td>Study</td>
<td>Study Design</td>
<td>Population</td>
<td>Methods</td>
<td>Results</td>
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<tr>
<td>(47) abs</td>
<td>Esophageal Cancer (U.S.) from 1998 to 2008 comparing mortality, complications, and failure to rescue between surgeon types. Wald chi-squared test to assess surgeon type and outcomes and multivariable logistic regression model.</td>
<td>(TS), or Cardiac surgeon (CS), or General surgeon (GS): had a 65% or more case mix in that specialty. If less than 65%, they were unclassified and used as a control group.</td>
<td>GS: 4086 cases In-hospital mortality: Unadjusted rates: Control: 8.2% TS: 4.7% CS: 13.7% GS: 6.7% Adjusted OR: TS vs. control: 1.11, p=0.55 CS vs. control: 1.06, p=0.82 GS vs. control: 1.87, p=0.04 Failure to rescue: Unadjusted rates: Control: 7.6% TS: 4.7% CS: 13.7% GS: 6.7% Adjusted OR: TS vs. control: 1.08, p=0.65 CS vs. control: 0.90, p=0.72 GS vs. control: 1.95, p=0.03</td>
<td></td>
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</tr>
<tr>
<td>Leigh, 2009 (48)</td>
<td>Esophageal Cancer Patients who underwent esophagectomy for esophageal cancer from April 1, 1998 to March 31, 2003. Retrospective cohort identified from the Hospital Episode Statistics database (U.K.) from April 1, 1998 to March 31, 2003 comparing mortality by hospital volume and surgeon specialty. Differences in mortality between specialties and between hospital volume categories were tested using chi-squared tests. Multivariable logistic regression adjusted by age, sex and SES-deprivation score.</td>
<td>Surgeon specialties: General surgeon (GS) vs. Cardiothoracic surgeon (CTS) (no definitions reported) Hospital volume cutoff (annual): HVH: ≥100 LVH: &lt;100</td>
<td>30-day and 90-day mortality: Surgeon specialty: GS: 6588 cases CTS: 2466 cases 30-day mortality: GS: 9.0% vs. CTS: 6.1%; p&lt;0.05 OR: 1.52 95% CI 1.27-1.83 Adjusted OR: 1.62 95% CI 1.34-1.96 90-day mortality: GS: 13.0% vs. CTS: 10.3%; p&lt;0.05 OR: 1.31 95% CI 1.13-1.51 Adjusted OR: 1.38 95% CI 1.18-1.61 Hospital volume: HVH: 3791 cases LVH: 5243 cases 30-day mortality: GS: 9.6% vs. HVH: 6.3%; p&lt;0.05 OR: 1.58 95% CI 1.35-1.86 Adjusted OR: 1.62 95% CI 1.38-1.91 90-day mortality: GS: 14.0% vs. HVH: 9.8%; p&lt;0.05 OR: 1.51 95% CI 1.32-1.72 Adjusted OR: 1.55 95% CI 1.35-1.77</td>
<td></td>
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<tr>
<td>Smith, 2008 (49)</td>
<td>Esophageal Cancer Patients who underwent esophagectomy from 2003 to 2007 in the U.S. Retrospective cohort from the University HealthSystem Consortium Clinical Database from 2003 to 2007 comparing LOS, perioperative complications, and in-hospital mortality by surgeon specialty. Continuous variables were analyzed using 2-sample t-tests and categorical variables by Pearson chi-squared tests.</td>
<td>Surgeon specialties: General surgeon (GS): general, vascular, and oncologic surgical training and certification labels. Cardiothoracic surgeon (CTS): cardiothoracic and/or thoracic surgery training and certification labels. Perioperative complications, LOS (ICU and hospital), and in-hospital mortality.</td>
<td>2657 total esophagectomies at 93 centres GS: 1079 cases CTS: 1578 cases Perioperative complications: GS: 55% vs. CTS: 52%; p=0.11 LOS-ICU (mean): GS: 8.4 days vs. CTS: 9.7 days; p=0.29 LOS-hospital (mean): GS: 16.6 days vs. CTS: 16.9 days; p=0.80 In-hospital mortality: GS: 3.6% vs. CTS: 2.9%; p=0.31</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
### Hospital and Surgeon Volume

**Chang, 2012**  
*Lung Cancer*  
Patients with lung cancer who received surgical treatment with or without adjuvant therapy in 2002. Also included other surgeries for other cancers.  
Retrospective cohort from the NHRI Research Database in Taiwan using data from 2002 to 2006. Kaplan-Meier survival curves compared using log-rank test; Cox proportional regression model to compare combined effect of surgeon and hospital volume on survival rates with adjustment for patient comorbidities, geographic location, type of residence, and treatment modalities.  
Hospital volume Cutoffs:  
- Low: <62  
- High: ≥62  
Surgeon volume Cutoffs:  
- Low: <6  
- High: ≥6  
5-year survival  
- LVH+LVS: 155 cases  
- LVH+HVS: 275 cases  
- HVH+LVS: 46 cases  
- HVH+HVS: 179 cases  
Unadjusted 5-year survival:  
- LVH+LVS: 30.3%  
- LVH+HVS: 44.7%  
- HVH+LVS: 43.5%  
- HVH+HVS: 53.1%  
Adjusted 5-year survival:  
- HVH+HVS: 50.2% vs. LVH+LVS: 39.5%, p<0.001, adjusted OR 1.67, 95% CI 1.02-2.73  
Authors reported statistically significant differences in 5-year survival for HVH vs. LVH (p=0.001) and for HVS vs. LVS (p<0.001) in favour of high volume groups; however no further data were reported for these comparisons.  
Multivariate regression analysis:  
- HVH+LVS vs. HVH+HVS: HR 1.33, 95% CI 0.85-2.08  
- LVH+HVS vs. HVH+HVS: HR 1.10, 95% CI 0.83-1.46  
- LVH+LVS vs. HVH+HVS: HR 1.82, 95% CI 1.35-2.46

**Derogar, 2013**  
*Esophageal Cancer*  
Patients with esophageal cancer who had an esophagectomy from January 1, 1987 to December 31, 2005.  
Retrospective cohort identified from the Swedish Cancer Registry. Multivariate parametric analysis adjusted for age, sex, Charlson comorbidity index, tumour stage at time of surgery, histological type of tumour, neoadjuvant therapy, and calendar period. Note: a subpopulation of this study was included in a study reported by Rouvelas et al (52). That study was included in the systematic reviews by Rouvelas et al (9), Gruen et al (3), and Wouters et al (2).  
Hospital volume  
- Low: ≤8  
- Medium: 9-16  
- High: ≥17  
Surgeon volume  
- Annual:  
  - Low: ≤4  
  - Medium: 5-9  
  - High: ≥10  
- Cumulative:  
  - Low: ≤11  
  - Medium: 12-32  
  - High: ≥33  
Overall mortality  
- Total of 1,335 esophagectomies.  
- Hospital volume:  
  - High: 299 cases  
  - Medium: 310 cases  
  - Low: 726 cases  
- Annual surgeon volume:  
  - High: 300 cases  
  - Medium: 355 cases  
  - Low: 680 cases  
- Cumulative surgeon volume:  
  - High: 330 cases  
  - Medium: 319 cases  
  - Low: 686 cases  
Multivariate regression analysis:  
- Med vs. Low: HR 0.96 95% CI 0.82-1.11  
- HVH+LVS vs. HVH+HVS: HR 1.33, 95% CI 0.85-2.08  
- LVH+HVS vs. HVH+HVS: HR 1.10, 95% CI 0.83-1.46  
- HVH+LVS vs. HVH+HVS: HR 0.97 95% CI 0.80-1.17

**Yasunaga, 2012**  
*Lung Cancer*  
Patients who underwent lung lobectomy (but not pneumonectomy) for lung cancer.  
Retrospective cohort using data from the Diagnosis Procedure Combination database.  
**Physician to bed ratio (PBR):**  
- Median PBR 19.7 physicians/100 beds  
**Postoperative complications, inhospital mortality, failure**  
**Esophagectomy:**  
- N=3917  
**Failure to rescue:**

### Other (Physical Resources, Collaborating Services, Human Resources, etc)

**Yasunaga, 2012**  
*Lung Cancer*  
Patients who underwent lung lobectomy (but not pneumonectomy) for lung cancer.  
Retrospective cohort using data from the Diagnosis Procedure Combination database.  
**Physician to bed ratio (PBR):**  
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**Postoperative complications, inhospital mortality, failure**  
**Esophagectomy:**  
- N=3917  
**Failure to rescue:**

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**Section 4: Document Review Summary and Review Tool**
| and Esophageal Cancer | lung cancer or esophagectomy for esophageal cancer from 2007-2008. This study also included gastrectomy for gastric cancer, colorectal cancer surgery, hepatectomy for hepatic cancer, and pancreatectomy for pancreatic cancer. and the Survey of Medical Institutions data from the Ministry of Health, Labour and Welfare of Japan from 2007-2008. Compared postoperative complications, inhospital mortality and failure to rescue by the physician to bed ratio and the nurse to bed ratio. Multivariate analyses to model outcomes by age, sex, Charlson comorbidity index, hospital volume and physician/nurse staffing using multi-level logistic regression. $\alpha=0.05$ Categories: Low PBR: <19.7/100 High PBR: $\geq$19.7/100 Nurse to bed ratio (NBR): Median NBR: 77.0 nurses/100 beds Categories: Low NBR: <77.0/100 High NBR: $\geq$77.0/100 PBR and NBR were combined into one of four possible categories for analysis: Group A: Low PBR, low NBR Group B: Low PBR, high NBR Group C: High PBR, low NBR Group D: High PBR, high NBR Hospital volume categories (used to model outcomes): Esophagectomies: Low: $\leq$9 Medium: 10-26 High: $\geq$27 Lung lobectomies: Low: $\leq$51 Medium: 52-106 High: $\geq$107 | to rescue (proportion of inhospital deaths among those who had experienced a postoperative complication). Only data on failure to rescue were reported for each type of surgery separately. Group A: 21.8% Group B: 18.7% Group C: 10.9% Group D: 13.8% P=0.001 Lung lobectomy: N=21639 Failure to rescue: Group A: 15.3% Group B: 12.9% Group C: 7.9% Group D: 5.9% P<0.001 |
| Ball, 2013 (54) abstract | Multi-disciplinary, goal-directed peri-operative management plan for patients having esophagectomy. | Doncaster Royal Infirmary, UK. Retrospective comparison of 2006-2009 cohort (before implementation of management plan) to 2010-2011 cohort (after implementation of management plan) | Before-and-after implementation of multi-disciplinary management plan. In-hospital mortality, morbidity. 2006-2009 cohort: 51 patients In hospital mortality: 21% 8 patients extubated at end of surgery. 1 patient mobilized on first post-op day. Median critical care stay, 8 days. 2010 to 2011 cohort: 29 patients In hospital mortality: 0% No statistical comparisons were reported. |
| Brooke, 2012 (55) abstract | Adherence to Leapfrog Group and National Quality Forum (NQF) safe practices. | 1,960 urban and rural hospitals in 41 states in the US. Cross-sectional study comparing hospitals that fully met the NQF Safe Practices (Full) to those that partially met them (Partial). (the Safe Practices are reported in the full publication) | In-hospital/30-day mortality. # of esophageal resections: Full NQF compliance: 1,974 cases Partial NQF compliance: 1,357 cases Mortality: Risk adjusted OR: 0.54 (95% CI 0.39-0.74) for full NQF compliance compared to partial. Complications: Full: 28.3%, Partial: 25.7%, p=NR |
| Kothari, 2010 (56) abstract | Patients who underwent esophagectomy three years pre- and post-adoption of an Acuity Adaptable Care Unit | Retrospective study comparing length of stay, 30-day mortality, and post-op complications for a 3-year period before | Before and after implementation of an AACU. LOS, 30-day mortality, post-op complications. Pre-AACU: 115 patients AACU: 119 patients LOS: Pre-AACU: 9d vs. AACU: 8d; p=0.21 |
|----------------------|----------|------------------|--------|-------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------|
|                      | Patients | Retrospective study of patients from the Royal Surrey County Hospital (RSCH), U.K., comparing complications, ICU stay, and hospital stay between patients pre-SPCP and post-SPCP as well as to a control group from 2009-2001 from the Virginia Mason Medical Centre (VMMC), Seattle U.S., where the same SCPC had been in use since 1991. | 30-day mortality: Pre-AACU: 0% vs. AACU: 1.6%; p=0.50 | Post-op complications: Pre-AACU: 58.3% vs. AACU: 51.3%; p=0.30 |
|                      | who       |                                                              |        | RSCH pre-SPCP: 12 patients | RSCH SPCP: 12 patients | VMMC SPCP: 74 patients | RSCH pre-SPCP: 12 patients |
|                      | underwent |                                                              |        | RSCH pre-SPCP: 75% vs. RSCH SPCP: 33.3%; p<0.05 | RSCH SPCP: 33.3% vs. VMMC SPCP: 47.3%; p=0.53 | ICU stay: RSCH pre-SPCP: 4 days vs. RSCH SPCP: 3 days; p<0.05 | ICU stay: RSCH pre-SPCP: 3 days vs. VMMC SPCP: 1 day; p<0.05 |
|                      | esophagectomy |                                                              |        | RSCH SPCP: 3 days vs. VMMC SPCP: 1 day; p<0.05 | Hospital stay: RSCH pre-SPCP: 17 days vs. RSCH SPCP: 7 days; p<0.05 | Hospital stay: RSCH SPCP: 7 days vs. VMMC SPCP: 8 days; p=0.25 |

Notes: HCUP-NIS: Health care utilization project national inpatient sample; HR: hazard ratio; HVH: high volume hospital; HVS=high volume surgeon; LOS: length of stay; LVH: low volume hospital; LVS=low volume surgeon; NCDB: National Cancer Database; NHI=National Health Insurance; NIS: Nationwide Inpatient Sample of the Healthcare Cost and Utilization Project; OR=odds ratio; SD=standard deviation; SES: socioeconomic status.

1. In addition to adjustments defined in Methods column, adjustment was also made for annual and cumulative surgeon volume.
2. In addition to adjustments defined in Methods column, adjustment was also made for cumulative surgeon volume.
3. In addition to adjustments defined in Methods column, adjustment was also made for cumulative surgeon volume and annual hospital volume.

See Appendix 1 for a list of identified studies that were included in at least one of the systematic reviews in Table 1. Please note that these studies were not included in Table 2.

Clinical Expert Interest Declaration:
The clinical expert, Dr. Sudhir Sundaresan, declared that he had no conflicts of interest.

Instructions. For each document, please respond YES or NO to all the questions below. Provide an explanation of each answer as necessary.

1. Does any of the newly identified evidence, on initial review, contradict the current recommendations, such that the current recommendations may cause harm or lead to unnecessary or improper treatment if followed? NO.

2. On initial review, a. Does the newly identified evidence support the existing recommendations? 2.a.) YES.
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Do the current recommendations cover all relevant subjects addressed by the evidence, such that no new recommendations are necessary?</td>
<td>2.b.) YES.</td>
</tr>
<tr>
<td>3. Is there a good reason (e.g., new stronger evidence will be published soon, changes to current recommendations are trivial or address very limited situations) to postpone updating the guideline? Answer Yes or No, and explain if necessary:</td>
<td>NO.</td>
</tr>
<tr>
<td>4. Do the PEBC and the DSG/GDG responsible for this document have the resources available to write a full update of this document within the next year?</td>
<td>YES.</td>
</tr>
</tbody>
</table>

**Review Outcome**

| Opinion of Clinical Reviewer: | The recommendations are valid and can be endorsed as is; however, the clinical reviewer feels that there may be merit in updating and rewriting the guideline as the evidence base is larger now and some recommendations could be stronger. |

**DSG/GDG Approval Date**

| March 4, 2015 |

**DSG/GDG Commentary**

| The 2015 Expert Panel on Thoracic Surgical Oncology reviewed the recommendation of the clinical reviewer to endorse and the new literature summarized in the review tool. All 17 members of the panel agreed that the 2005 recommendations could be endorsed, that minor changes to the wording of the recommendations for clarification were reasonable (these are noted above). It was noted in discussion that the additional literature is still insufficient to make specific recommendations regarding target surgical volumes but that the original 2005 consensus recommendations based on the expert opinion of the original panel were reasonable and should continue to guide practice in Ontario. |

| Since 2005, several guidance documents have been developed by CCO that are relevant to the Thoracic Standards. An updated inventory of these documents has been added to the Recommendations Section 1, and should be used to guide practice. |
REFERENCES


APPENDIX 1. EBS #17-1: Thoracic Surgical Oncology Standards. Screening of Literature Search Results

Introduction
Cancer Care Ontario (CCO) asked the PEBC to update evidence-based series (EBS) #17-1 as the last literature search was conducted more than 10 years ago. The original literature search could not be found and the PEBC had to recreate a search strategy. This new strategy returned 19,263 non-duplicate citations identified from the databases of MEDLINE via OVID (2004 to November Week 3, 2013 [Dec 23, 2013]), EMBASE via OVID (2004 to 2013 Week 51 [Dec 23, 2013]) and the Cochrane Library via OVID (CDSR [Nov 2013], CCTR [Nov 2013], DARE [4th Quarter 2013]).

Given the very large number of citations to screen and given the high priority that CCO attached to the update of this guideline, a decision was made to utilize additional staff resources in the title and abstract phase of the screening process. The objective of this process was to eliminate, as efficiently as possible, the obviously ineligible studies from further consideration and to keep any citations that either clearly met the eligibility criteria or for which it was not possible to determine eligibility simply from the title and abstract (i.e., full text review would be required).

Methods
Prior to screening, an orientation meeting was held with the five research coordinators (Adam Haynes, Judy Brown, Raymond Poon, Lisa Durocher, Sam Craigie) assigned to the project. Each research coordinator was provided with a document summarizing the original systematic review question and original study eligibility criteria (see Eligibility Criteria below). The eligibility criteria were presented at the meeting and expanded upon (but not altered from the original intent) based on discussion and agreement between the research coordinators.

A pseudo-random set of 500 citations was identified from the primary database of 19,764 citations. This set of 500 was screened in quintuplicate. The results of each research coordinator’s review was entered into an Excel spreadsheet in order to calculate an agreement score using Fleiss’ kappa using two categories: exclude vs. include/maybe. Records that had discrepant results (i.e., where one or more reviewers had a different screening result than other reviewers; e.g., four reviewers indicated a record should be excluded, but one reviewer indicated the same record was include or unsure) were identified. These records were discussed in a follow-up meeting where the research coordinators discussed the different results in order to come to agreement on the screening result (e.g., include, exclude, or maybe).

Results
When considering only two possible screening results (exclude or include/maybe), of the 500 random citations, 474 had concordant results between the research coordinators. Of note, three of those 474 records differed by assignment to include or maybe categories; however, for the purposes of this project, that was deemed an acceptable outcome as all records categorized to ‘include’ and ‘maybe’ were to be retrieved for further full text review. Twenty-six records had discordant results where one or more research coordinators assigned a category to a record that was different than the category assigned by the remaining research coordinators.
Eligibility Criteria

Original Study Eligibility Criteria

Inclusion Criteria
Reports were selected for inclusion in this systematic review of the evidence if they reported information on organizational resources relating to improved outcomes for patients undergoing cancer-related thoracic surgery. Patient-related outcomes of interest include: tumour response, local disease control, survival, adverse events, or quality of life.

Practice guidelines, meta-analyses, or systematic reviews related to the research question were also eligible for inclusion in the systematic review of the evidence.

Further information (not explicitly stated in original inclusion criteria):

- **Cancer-related thoracic surgery**: surgery for lung or esophageal cancer. In theory this would also include thymomas.
- **Organizational resources included the following factors**: management of human, hospital and health care system resources.
  - The guideline addressed the following issues as they related to the outcomes of interest:
    - Surgeon criteria (education, training, expertise/specialty, experience)
    - Practice setting [e.g., hospital type, designated treatment centres (e.g., cancer centre, etc), non-designated centres (e.g., general hospital)]
    - Volume of thoracic surgery* (from the aspect of treatment centre and surgeon)
    - Hospital criteria physical resources and collaborating services required to provide thoracic cancer surgery
    - Human resources (surgeons, anesthesiologists, other medical specialists, allied health professionals (nurses, physiotherapists, respiratory therapists, dieticians/nutritionists, home care workers, social workers, pharmacy staff, palliative care professionals, etc)
    - Organizational criteria (e.g., how patients move through the system, how services are organized and offered to patients, organization of multidisciplinary teams, etc).
- **Outcomes included in guideline but not stated in inclusion criteria**:
  - Length of stay
  - Morbidity
  - 30-day mortality

Note: *This seemed to be the focus of guideline and most of the included studies.

Exclusion Criteria
Articles were excluded from the systematic review of the evidence if they reported information on thoracic surgeries for tumours in locations other than the lung or esophagus, if they were published or developed prior to 1990 and/or were in a language other than English.

Further information (not explicitly stated in the original exclusion criteria):
Exclude letters, editorials, comments, news articles, narrative reviews, non-English papers.
APPENDIX 2. List of Identified Studies Included in at Least One of the Systematic Reviews in Table 1.
Note: these studies were not included in Table 2.


Fujita H, Ozawa S, Kuwano H, Ueda Y, Hattori S, Yanagawa T. Esophagectomy for cancer - Clinical concerns support centralizing operations to within the larger hospitals. Dis Esophagus. 2010 August;23:15A.


Lin HC, Xirasagar S, Lee HC, Chai CY. Hospital volume and inpatient mortality after cancer-


Simunovic M, Rempel E, Theriault ME, Coates A, Whelan T, Holowaty E, et al. Influence of


Urbach DR, Bell CM, Austin PC. Differences in operative mortality between high- and low-volume hospitals in Ontario for 5 major surgical procedures: Estimating the number of lives potentially saved through regionalization. CMAJ. 2003 27 May;168(11):1409-14.


Appendix 3: Members of the Expert Panel in March 2015

The 2015 Expert Panel was convened to include representation from across Ontario and across professional disciplines (surgery, pathology, radiology, medical oncology and radiation oncology).

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Hospital/Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Gail Darling (Co-Chair), Surgeon</td>
<td>Dr. Alice Wei (Co-Chair), Surgeon</td>
<td>Toronto General Hospital</td>
</tr>
<tr>
<td>Dr. Claudia Den Boer Grima</td>
<td>Dr. John Dickie, Surgeon</td>
<td>Windsor Regional Cancer Program</td>
</tr>
<tr>
<td>Dr. Peter Ellis, Medical Oncologist</td>
<td>Dr. David Ewing-Bui, Surgeon</td>
<td>Juravinski Cancer Centre, Hamilton</td>
</tr>
<tr>
<td>Dr. Kenneth Gehman, Surgeon</td>
<td>Dr. Marcio Gomes, Pathologist</td>
<td>Thunder Bay</td>
</tr>
<tr>
<td>Dr. David Hwang, Pathologist</td>
<td>Dr. Jonathan Irish</td>
<td>Toronto General Hospital</td>
</tr>
<tr>
<td>Dr. Neil Johnson</td>
<td>Dr. Richard Malthaner, Surgeon</td>
<td>Regional Vice-President London Regional Cancer Program</td>
</tr>
<tr>
<td>Dr. Craig McFadyen</td>
<td>Dr. Yaron Shargall, Surgeon</td>
<td>Regional Vice-President Carlo Fidani Peel Regional Cancer Program</td>
</tr>
<tr>
<td>Dr. Amit Singurkar, Nuclear Medicine</td>
<td>Dr. Julius Toth, Surgeon</td>
<td>Hamilton Health Sciences</td>
</tr>
<tr>
<td>Dr. Yee Ung, Radiation Oncologist</td>
<td></td>
<td>Odette Cancer Centre</td>
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<tr>
<td></td>
<td></td>
<td>Toronto</td>
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</tbody>
</table>
Appendix 4- Document Assessment and Review Outcome Definitions

1. **EDUCATION AND INFORMATION** - An education and information document is a document that will no longer be tracked or updated but may still be useful for academic or other informational purposes. The document is moved to a separate section of our website, each page is watermarked with the word “EDUCATION AND INFORMATION”.

2. **ENDORSED** - An endorsed document is a document that the DSG/GDG has reviewed for currency and relevance and determined to be still useful as guidance for clinical decision making. A document may be endorsed because the DSG/GDG feels the current recommendations and evidence are sufficient, or it may be endorsed after a literature search uncovers no evidence that would alter the recommendations in any important way.

3. **DELAY** - A delay means that there is reason to believe new, important evidence will be released within the next year that should be considered before taking further action.

4. **UPDATE** - An Update means that the DSG/GDG recognizes that there is new evidence that makes changes to the existing recommendations in the guideline necessary but these changes are more involved and significant than can be accomplished through the Document Assessment and Review process. The DSG/GDG will rewrite the guideline at the earliest opportunity to reflect this new evidence. Until that time, the document will still be available as its existing recommendations are still of some use in clinical decision making.